			For State Registrar	ate of Maryland		rtment of h		and Mer		giene Reg. No C	109	40001
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		50	chuppn	er		Date of Dea Month	Day	Year 2007	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location	of Death	0 00. 110	4c. Cour	nty of Death	
*	Funeral		The Johns Hopkins Hosp 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8.	Date of Birth	n (Year)	9. Birth	place (State or Foreign
li	Director		218-18-0942 1 🛣 M	^{2 □ F} 84	Yrs.	Worth's Days	Tiodis	Ja	(Month, Day anuary	16,1925	Mary.	land
	ryland show at	_	10a. State 10b. County		Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma 28a-f otified	Directo	Maryland Howard 10e. Street and Number	E11	licott	City 10f. Zip-Code				10g. Citizen o	f What Cou	
	h with 23a or st be n	al Di	10230 Green Clover Drive	2		21042				U.S		
	items items	Funeral	Fi. Walital Status	Vas Decedent Ever in U.S.	13. V	Vas Decedent of F Yes, specify Cub	lispanic Or an, Mexicai	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	14. R	ace - Ameri Iack, White,	
036	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 3 Widowed 4 Divorced	Yes 2 No Yes, Give 'ear or Dates:	1	☐ Yes 2 🛣 No	Specify.	:		Spe		White
21215-0036	"natur "adical I	Completed	15. Decedent's Educatio (Specify only highest grade cor	mpleted)	(Give	lent's Usual Occu kind of work done OO NOT use retire	during mos	st of working		16b. Kind of	Business/I	ndustry
212	filed within 72 h I Hygiene. other than "natu ent, the Medical	omp	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)		Shoreman					Oil Ca	mpany
	uld be file fental Hy rked othe iic event,	Be	17. Father's Name (First, Middle, Last) Wells Schupper					ier's Name <i>(F</i> Ruth ELI		Maiden Surr	name)	
Maryland		2	19a. Informant's Name/Relationship (Type. F	Print)	19b. Mailir	ng Address (Stree				er, City or Tov	vn, State, Zi	p Code)
	nd 2 lith a 27 is		Ronald R. Hogg (frie			ogg Court	Fllic		-	yland 21		Charles
ore	Pages 1 an nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Remo	val from State ce.	metery, cren	sition (Name of natory or other pla Memorial P		Date 12–18–2		20c. Locatio		e, Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service licensee	/		Name and Addr				TEILTIOC	WY III	z, ren yana
ñ	a II De		23a. Part 1. Enter the disease, or complication	one that caused the death	5	555 Twin K	nolls l	Road Co	olumbia	, <u>J</u>	nd 210	45 Approximate
d	Thursialan	i K Di	shock, or heart failure. List only one ca	use on each line.	DO NOT CITE	er the mode or dy	ing, such a	0 0010100 07 1	oop natory a	,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Du to (or as a conseque	ence of):							
	Examiner	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of);							
g.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C								-	
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):							
68760,	certificate be executed ding physician and use as the burial-transit	Aedical	d			***	_					
Box	v requires that the death certifice been signed by the attending I should be detached for use as	Physician/M	in the past 12 months?	f yes, outcome of pregnan	death 3 🗆	Ectopic pregnan	су				Date of deli Month	very Day Year
	the dea the at thed for	hysic	1 Vec 2 No	4 ☐ Pregnant at time of dea ∃ ☐ Unknown	atn 5	Other (specify) _						
s, P.O.	The law requires that the death te has been signed by the atten page 2 should be detached for 1	by P	Part II. Other significant conditions contribu	uting to death but not resu	Iting in the u	ınderlying cause ç	given in Par	t I.	23e. Did to			the cause of death?
Records,	v require been sig should	eted							24a. Was	an 24	b. Were au	topsy findings available
	ne lav has l ge 2	Completed							autop perfo 1 Yes	rmed? 2 No	prior to death?	completion of cause of
Division of Vital		Be	25. Was case referred to medical examiner?	pital: — d		. Ot	har	e of Death (C			011	***
TO I	Physic rthis o eral dir	2	27. Manner of Death 2	1 Unpatient 2 L E	R/Outpatien 28b. Time o Injury	1 3 LI DOA	ıry at			dence 6 -		ny)
sion	tending Fleath. or: After the funer	catio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2	-	f Location (Street and No	imber or Pi	ıral Route Number,
$\overline{\underline{S}}$	lor Att after d Directe f in by	Certification:	4 Homicide determined	 Place of injury - At hon building, etc. (Specify) 	ne, iaim, su	eet, lactory, office		20	City or Tow		imber of rie	a risate rames,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and property after this certification by the funeral director.	edical C	(check only 2 Medical Examiner:	n: To the best of my know On the basis of examination	ledge, death on and/or in	occurred at the t vestigation, in my	ime, date a opinion, de	and place, an	d due to the d at the time,	cause(s) and date and pla	manner as	stated. e to the cause(s)
	To the P within 2 To the F complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number			29d. Date sig	ned (Month	, Day, Year)
	F S F O		> Milfr			RES	5 000)		Deceml	per 0	6,2009
	10		30. Name and address of person who comp	1	23a) (Type,	Print)		600 No	orth Wo	olfe St. E	Baltimo	ore, MD, 21287
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re /			555.14		,		-,,
	Regist	rar	DEC 15 2009	Comment of the state of the sta	. 136	NEW YORK						

			State of Maryl 1- State Registrar 1. Decedent's Name (First, Middle, Last)	and / Depa <i>Cer</i>	artment of Health and tificate of Death	Mental Hygi	ene s. No.2009 40002
1	Physici /Medi	cal	4a. Facility Name If not institution, give street and number)	Sc	4b. City, Town, or Location of Dea	2. Date of Death Month Per Cm	Bay 12 Year 21'.31 PM 4c. County of Death
)	Examir	1er	The Johns Hopkins Hospital		Baltimore City	au i	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y	yrs. last birthday) 64 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Min		(ear) 1945 9. Birthplace (State or Foreign Country) PA
:	e Maryland 8a-f show tiffed at	Director		City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2X No
:	With the	Dir	10e. Street and Number 2 Hiawatha Trail		10f. Zip-Code 19966		g. Citizen of What Country? United States
9036	penim. Fages I and 2 should be filed within 72 hours after death with the Maryland appearment of Health and Mential Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 🗶 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	. 14. Race - American Indian, Black, White, etc. Specify: White
1215-	witnin 72 n ene. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired) COMER Service Re	orking	6b. Kind of Business/Industry Grocery
Maryland 21215-0036	Mental Hyginarked other arked other itic event, the	To Be Co	17. Father's Name (First, Middle, Last) Charles E. Frederick		18. Mother's N	ame (First, Middle, Mi a Matz	aiden Surname)
, Mar	and 2 sno ealth and I n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type. Print) Daniel Scheidt, Husband		ng Address (Street and Number or a awatha Trail, Mi		
Baltimore,	ment of H ant: If iter ury or oth		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		natory or other place) proten of Memories 12,	/16/2009 Li	oc. Location - City or Town, State imerick, Pennsylvania
Balt	Depart Import any inj once.	ā	21. Signature of Fifteral Service Licensee T. Harman	Ho	ome, 359 King St	reet, Pott	
	hysician		23a. Part 1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each lige. Immediate Cause (Final disease or condition	eath. Do not ente	er the mode of dying, such as cardi	ac or respiratory arres	st, Approximate Interval Between Onset and Death
	Medical xaminer	_	resulting in death) Due to or as a cons	sequence of):			
8	ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution o				
8760,	physician at the burial	edical E	d.	requerice ory.			
O. Box 68760, 🔫	the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P.O.	been signed by the attershould be detached for	þ	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
He law	10 gp Cl	Completed				24a. Was an autopsy performe	d? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	ertifica ector,	Be (25. Was case referred to medical examiner?			ath (Check only one)	
	After this or funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred
DIVISION or Attending	after death. Director: After this d in by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spe	home, farm, stre		28f. Location (Stre City or Town, S	et and Number or Rural Route Number, state)
To the Hospital	within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier (check only one) Certifying Physician: To the best of my k (maintain the basis of examinand manner stated.	nowledge, death ination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the cau curred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
Toth	within To th comp	M	29b. Signature and title of conflier		29c. License number		. Date signed (Month, Day, Year)
			100		RES-000		December 12, 2009
	Sta		30. Name and address of person who completed cause of death (I		600	North Wolfe	e St, Baltimore, MD, 21287
	Registra		DEC 15 2009 Janua	nature.	who		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year **Physician** RUTH SCHRUMPF 10, 19:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner tranklin Square 1-6521791 Kosedale Battimore (enter 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 9, **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 136-18-7972 78 Director 1921 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examination at MD Baltimore 1 ☐ Yes 2 ☐ No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Eastern Boulevard 21221 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No White ģ Specify 3 Widowed 4 □ Divorced s 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
Item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hauff Cunningham Sarah Albee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Schrumpf, Son 9922 Great Oaks Way, Fairfax, VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holmdel Cemetery Holmdel, New Jersey 12/19/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral rvice Licensee 22. Name and Address of Facility Kedz Funeral Home Harman 1123 Hooper Ave., Toms River, NJ 08753 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner oronary Eaguer Holly list our diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Derten sician and burial-trans Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ed by the a signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy certificate 2 No 2 No 1 □ Yes 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No ER/Outpatient 3 ☐ DOA this 1 Inpatient Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Box 68760 P.0. Records, Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

> State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

guare

29d. Date signed (Month, Day, Year)

imore, MD 21237

and manner stated

tranklin S

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 40004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anne B. Shearer 2:35 P M 2009 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth's Nursing Center N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 D M 2 XX (Month, Day, Year)
Peb 20, 1916 Months Days Hours 212-03-6253 **Director** 93 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Howard Columbia MD 1 Yes 24 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6405 Four Foot Trail 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: White 3 ▼Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Insurance Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence P. Bunting Ada M. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory R. Shearer (Son) 6405 Four Foot Trail Columbia, MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemtery 12/16/09 Baltimore, MD 21. Signature of Funeral Service Liber ee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final genenta Onset and Death Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): _xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated exects.) Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown ate has been signed by the atte page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cru 10113109 RIIIGIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Goldsbergugh 3320 Benso Ave Baltimore MO 32. Registrar's agnatur Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10, Larry Eugene December 6:16P M Spoone 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 924 Hopkins Corner Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 1) Feb. 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday **Funeral** 218-74-7662 50 Feb. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Medical Exprision is used to instiff of once. 1 ☐ Yes 2 🖾 No Director MD Anne Arundel Millersville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 8272 Ahearn Drive 21108 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 14. Race - American Indian 11. Marital Status □Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Ş Q Specify: White 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) District Manager Auto Parts Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Larry Allan Spoone ဂ္ Barbara Ann Trumphower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shaina M. Rober/Daughter 924 Hopkins Corner Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 15, 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): ears Examiner (JRU 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner?) aughter's 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home RES2DENCE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 8 Other (Specify) Certification: To 5 Residence 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury Injury at Work? 5 Pending investigation 1 □Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated

within 24 hours a

To the Funeral I

State Registrar 29b. Signature and title of certifier

(501

Maye

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

32. Registrar's Signature

DHMH 17 Rev 1/200

203405pilal

29c. License number

29d. Date signed (Month, Day, Year)

Prive Glea Burne MD 21061

December 11,2009

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		for State Registrar		Otato	01 111	ai yiaii		rtificate of			violitai		. No. 2	009	40006
		Decedent's Nam	ne (First, Midd	lle, Last)							2. Date o	of Death		V	3. Time of Death
Physicia /Medic		Nelson	n Edwi	in Schee	ere	r, S	r.				Dece		10,	2009	12:50 P ^M
Examin		4a. Facility Name (,			4b. City, Town, o		of Death	1		4c. Cour	nty of Deat	h
<u> </u>		5500 P 5. Social Security N		ield Av			last birthday	Baltimo		er 24 Hrs.	8. Date of	of Rinth		9 Rin	thplace (State or Foreign
Funeral Director		219–26–56	569	1 M 2 □ F			1 Yrs.	Months Days		Min.	(Mont	h, Day, Y	6a <i>r)</i> 38	Co	yland
land ow		Usual Residence of 10a. State	10b. County	/		10c. Cit	y, Town or Lo	ocation		·					10d. Inside City Limits
Mary a-fsh	tor	MD				Balt	imore								1 XVes 2 □ No
th the	Director	10e. Street and Nu	mber					10f. Zip Code				10g	. Citizen	of What Co	ountry?
ath wi		5500 Pla	infiel					21206					SA		
ler de Items	Funeral	 Marital Status Never Marr 	riod 2 Ma	12. Was D	ecedent Forces s 2	Ever in U.	S. 13.	Was Decedent of ! If Yes, specify Cub	Hispanic C oan, Mexica	origin? (Span, Puerto	pecify Yes o o Rican, etc	or No-)		Race - Ame Black, White	erican Indian, e, etc.
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other than "natural", or Items 23e or 28e-f show event, the Medical Exeminer must be notified at	by	3 Widowed	_		Give r Dates:	140		1 ☐ Yes 2X No	Specif	y:			Spe	cify: Wh	ite
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id be i ental ked o ic eve	To Be	17. Table of Table	(iioi, iiioaio,	, 2001)				(unk)			ence			,	
nd 2 should be filed within and 2 should be filed within all with and Mortal Hygiens 27 is marked other than traumatic event, In Mortal Andrea of the Mortal Office of the Mortal	F	19a. Informant's N	lame/Relation	ship (Type. Print)			19b. Mail	ing Address (Stree	t and Num	ber or Ru	ıral Route N	lumber, C	City or To	vn, State, .	Zip Code)
1 and 2 Health a tem 27 is		Donna S.	Marte	ney/daugl	nter		5500	Plainfie	eld Av	æ. E	Baltim	ore,	MD .	21206	
Pages 1: nent of He int; if iten		20a. Method of Dis		3 ☐ Removal fro	ım State	20b. F	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)		Date			-	Town, State
그는 문문 등		4 ☐ Donation	5 Other (Specify)		Fir		urney Cre						ine,	
permi Depar Impo eny ir		21. Signature of Fi	uneral Service	Licensee				22. Name and Addr 51ng Home							
		23a. Part 1. Enter 1	the disease, c	or complications that	at cause	d the deat		everly L. Inter the mode of dy						svill	e, MD 21029 Approximate
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/Medical		disease or condition resulting in death)			mall to (or as	a conseq	uence of):	g coorie	V						8 months
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be executed sician and burial-transit	Examiner	that initiated event resulting in death)	S	c	to (or as	a conseq	uence of):								
ficate be ex physician as the burial	edical F			d											
rtifica ng ph as th	/ledi	IE EEMALE.					(Pod 4)								
The law requires that the death certificate atte has been signed by the attending physicage 2 should be detached for use as the teached	Physician/M	IF FEMALE: 23b. Was deceder in the past 12			ve birth	2 🗀 Feta	I death 3	☐ Ectopic pregnan	псу					Date of de	livery Day Year
he dea the a	ysici	1 ☐Yes 2	□No		regnant : nknown	at time of o	death 5	Other (specify)	-					WOTE	Day 16ai
that the dended by the a		Part II. Other signi		ions contributing to	o death t	out not res	ulting in the (underlying cause gi	iven in Pari	t I.	23e.	Did toba	cco use c	ontribute t	the cause of death?
w requires been sign should be	d by											1 ☐ Yes	2 🗆 N	0 3 ★ P	robably 4 🗆 Unknown
aw rec as bee 2 shou	Completed											Was an	24	b. Were a	utopsy findings available
The Is	mo										_	autopsy performe Yes 2	ed?	death?	completion of cause of s 2 □ No
ysiclen: is certifica	Be C	25. Was case refe examiner?	rred to medica	al					26. Pla	ce of Dea	ath (Check				<u> </u>
hysic this co	ဥ	1 ☐ Yes 2 🔀	(No					SILL SILL DOA		Nursing H	lome 5	Residen	ce 6 🗆	Other (Spe	ecify)
After After funera	jon:	27. Manner of Dea	5 Pendi	ing (N	ate of Inj Ionth, D	ury a <i>y, Year)</i>	28b. Time o Injury	Wo		¬ы.	28d. Desc	cribe how	injury oc	curred	
Attending Physicien: r death. ector: After this certific by the funeral director, i	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could		ace of In	iurv - At h	ome, farm, st	treet, factory, office	□Yes 2[28f. Local	tion (Stre	et and Ni	ımber or A	ural Route Number,
al or / s after I Dire	Certification:	4 🗌 Homicide	deten			tc. (Specia		,,,				or Town,		<i>31111</i> 01 01 11	ara, riouto rrambol,
To the Hospital or Attending Physical Within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Medical (29a. Certifier (Check only one)		I Examiner: On th		of examina		ath occurred at the investigation, in my							
Fo the vithin Fo the comple	Mec	29b. Signature and	d title of certifi		anner S	iaiou,		29c. Licen	nse numbe	r		290	d. Date sig	gned (Mon	th, Day, Year)
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Sta Registr		31. Date filed (Mor	1 5 200	Deneus	. Hegist	rags Sign	THE PARTY OF	·							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 11 **Physician** Day 22 Year 9 James Edward Taylor 6:50 avm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, Joseph Ritchie House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 □ F Months Hours Country)
MD 216-20-4934 84 Director May 5, 1925 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at Director MD Baltimore 1√2Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Dolphin Street 21217 U.S. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 ☐ Widowed 4 ☑ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygier Is marked other th construction worker 9th construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked ofthe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harriet Hattiespence ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Gibson/ daughter 501 Dolphin St. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremetory
22. Name and Address of Facility 12/7/09 Glen Burnie, MD 21. Signature of Puneral Service Licensee Skarda Funeral Home 2829 Hudson StMD nomas 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 months disease or condition resulting in death) stage /Medical Due to (or as a conse nince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2☐No Ö detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown onset diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an in by the funeral director, page 2 s autopsy 2XNo al or Attending Physician: Tis after death.
Il Director: After this certificat 1 ☐ Yes 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) H 0501CC 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D51788 11-23-2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Polk Bel Air MD Z1014 620 Boulton Tim MD 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State Registrar

ACLOR

JAMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 60008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2009 **Physician** 1:27 8.0 BILLY THOMAS JR. 12 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 429-48-9275 79 Director 8-1-1930 ARKANSAS Usual Residence of Decedent 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c City Town or Location 10a State 28a-f show d other than "natural", or items 23a or 28a-f shevent, if a Modical Examiner must be notified 1 ☐ Yes 2 🛛 No Director HARFORD ABERDEEN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 354 GRACEFORD DRIVE U.S.A. 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) A 27 is marked other than "r traumatic event" Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 12 SCHOOL BUS DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ WILL THOMAS HENRIETTA THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important: If item 27 any Injury or other trong. Grace Thomas/Wife 354 Graceford Drive., Aberdeen, Md., 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL 12-12-09 ABERDEEN, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATOR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Box 68760, attending p for use as t IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Ö certificate has been signed by the rector, page 2 should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by RENAL DISEASE END STAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **I**No 1 ∐ Yes 2 🖬 🗖 🗖 🗖 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending spital or Attendinours after death.
neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

To the within 2 within 2 To the To the compile

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUION AVE HAUTE de GRACE, MO 21078

31. Date filed (Month, Day, Year)

TEC 15 2009

A Segistrar's gignature

TEC 15 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 9
State of Maryland / Department of Health and Mental Hygiene 40009

			1 - For State Registrar	State of Mary		Certificate o		-	Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, La	Leonard	I Tohn '	Burner		2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic							Decembe	r 14,	2009	6:35 A M
1	Examin	er	4a. Facility Name (If not institution, giv				or Location of De	ath		ounty of Death	
	Funcion		Keswick MultiCare 5. Social Security Number 6. S		n yrs. last birth	Baltir		rs. 8. Date of Bir		/A	place (State or Foreign
	Funeral Director		214–40–7699 Usual Residence of Decedent	X M 2□ F		rs. Months Day	s Hours Mi	n. 8. Date of Bir (Month, Da March	23, 19	43 MD	
	/land		10a. State 10b. County	10	Oc. City, Town	or Location				1	0d. Inside City Limits
	a-f st	ctor	MD N/A	j	Baltimo	ore					XXYes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	•
	ath w 3 23a	Funeral Director	3939 Roland Avenu			212				U.S.A	<u> </u>
	items items	n.	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever	r in U.S.	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 14	 Race - Americ Black, White, 	
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinet must be notified at	þ	3 ☐ Widowed 4√☐ Divorced	1 □Yes 2 → Yo If Yes, Give Year or Dates:		1 □Yes 2√XW	o Specify:		S	Specify: W	hite
2-0	72 hou	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a. [Decedent's Usual Occ	upation	orking.	16b. Kind	d of Business/In	dustry
21	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	CC	Give kind of work don life. DO NOT use reti Instruction	e during most of w red) 1	Orking	· Ra	ltimore	City
7	led w Hygier her th	S	9th					ame (First, Middle,			СТСУ
and	d be fi	Be c	17. Father's Name (First, Middle, Last)	Edward E.	Turner	•		Elizabet		,	
aryl	should nd Me mark imark	٦.	19a. Informant's Name/Relationship (Type. Print)	19b, I	Mailing Address (Stre					Code)
Š	alth a 27 Is		Virginia Barksda	le (Niece)	T	19 Clearwo		Parkvil			
ore	es 1 a of He of He fitem		20a. Method of Disposition	15. 14. 6	20b. Place of D	Disposition (Name of crematory or other p	lace)	Date		ation - City or To	own, State
Ĕ	Pag ment ant; I ury o		1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		Valley Me	emorial			onium,	MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, It is The deal Examiner must be notified anone.		21. Signature of Funeral Service	ee/	-	22. Name and Add Burgee-He 3631 Fall	ress of Facility enss—Seit	z Funera	l Home	e, Inc.	
			23a. Part 1. Enter the disease, br com shock, or heart failure. List only	plications that caused the	e death. Do no	t enter the mode of d	ying, such as card	iac or respiratory a	rrest,	211	Approximate Interval Between
· var	Physician		Immediate Cause (Final disease or condition			ing Canc					Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of	i d	01 0000				provide S
	Examiner	<u>.</u>	Sequentially list conditions,	b							
	rted nsit	Examiner	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of	ľ					
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68760,	rificate be executed ng physician and as the burial-transit	cal		. d							
9	ntifica ng ph as th	ledi	IF FEMALE.								
Вох	ath ce ttendii or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregna	ncy		23	d. Date of deliv	•
P.O.	ne dea the a	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tirr 9 ☐ Unknown	ne of death	5 ☐ Other (specify)				Month	Day Year
σ.	that ti ed by detac	F.	Part II. Other significant conditions of	ontributing to death but n	ot resulting in t	he underlying cause of	given in Part I.	23e. Did t	obacco use	e contribute to t	he cause of death?
Division of Vital Records,	quires an sign	d by						1 🗆 '	Yes 2□	No 3 ☐ Prot	pably 4 Hnknown
၀၁	aw rei	Completed						24a. Was		24b. Were auto	ppsy findings available
Ĕ	hysician: The le his certificate ha I director, page 2	E O						- autop perfo 1 □ Yes	osy rmed? 2 ☑ No	prior to co death? 1 ☐ Yes	mpletion of cause of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?					eath (Check only o			
<u></u>	Physic this c		1 ☐ Yes 2 ☐ MYO			Alleni 3 L DOA		Home 5 ☐ Resi	dence 6 [Other (Special	(y)
'n	Jing F	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ear) 28b. Tir Inji	ury W	ork?	28d. Describe I	how injury o	occurred	
isi.	Attender death	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Hamiside determined		- At home, farn	n, street, factory, office	□Yes 2□No	28f. Location (Street and i	Number or Bura	al Route Number,
2	ital or / irs after ral Dire	Certification: To	4 Homicide determined	building, etc. (S	Specify)	, , , , , , , , , , , , , , , , , , , ,		City or To			,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death within 124 hours after death. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of m niner: On the basis of exa and manner stated	amination and	death occurred at the or investigation, in my	time, date and pla opinion, death oc	ace, and due to the curred at the time,	cause(s) a date and p	and manner as s place, and due to	stated. the cause(s)
	To th withit To th comp	Me	29b. Signature and title of certifler			29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
			heron Black	mo		0000	11199		0000	14. 200	i
	5.1		30. Name and address of person who	completed cause of death	h (Item 23a) (T		C 1 111	- 1	1.4	> 0.40	- //
	JV		31. Date filed (Month) Day, Mear)	32. Registrar's	Signature	res st	Jute 410	Jilanson	1 M	0 2121	24
	Sta	(e)	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Oz. negistiars	rynature	. 0 0					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14, 200 Year Dec. Terzigni 9:25 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F Months 216-16-2231 **Director** 85 Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ems 23a or 28a-f sho must be notified at Director 10d. Inside City Limits Baltimore Phoenix MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21131 59 Windemere Parkway 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? should be filed within 72 hours after cand Mental Hygiene.

is marked other than "natural", or þ 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Americo Panza Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tra Mary E. Lutz - daughter 59 Windemere Parkway Phoenix, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12-18-09 4 Donation 5 X Other (Specify) Entomb Timonium, Maryland 21. Signature neral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling Street Balto. Md. 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he if failux. List only one cause on each line. Approximate Interval Between Immediate Caus (Find disease or condition resulting in death) Onset and Death Physician/ END STAGE RENAL DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury) Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Furneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burneral process. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) No Pregnant at time of death Day Year 1 ☐ Yes 2.43 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 X No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 1 ☐ Yes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the 29c. License number 2009 6 person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES.
31. Date filed (Month, Day, Year) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signatur

State Registrar

a.m.

2009

DECEMBER

			For State	State of Maryland	•			l Mental Hy	21	009	40011
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of De	neg. No.	100	1
	Physicia		JENETTE TERRY					Month DECEMB	Dav	2009	3. Time of Death 1:47a ^M
_	Medic Examin		4a. Facility Name (if not institution, give str	reet and number)	_	4b. City, Town, or	Location of Dea		- 1	nty of Death	1.474
	,		GILCHRIST HOSPIC	E CENTER		TOWS				LTIMO	RE
	Funeral Director		213-01-480	M 2 □XF 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours Min		th ly, <i>Year)</i> 1920	9. Birth Coun MARY	place (State or Foreign htry) LAND
	how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City Limits
	arylar a-fsl	Director	MD. N/A	BA	LTIMO	RE					1 X Yes 2 □ No
	or 28 e not	Ϊ	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	s 23a ust b	Funeral	1700 MT. ROYAL			21217			USA	1	
	death item		11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Specify Yes or No-		ace - Americ	
21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		☐ Yes 2 🗓 No				lack, White, ify: BLA	
<u>7</u>	72 hor "nat	ple	15. Decedent's Educ (Specify only highest grade		(Give k	ent's Usual Occupa and of work done du		orking	16b. Kind of		
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	filed within al Hygiene. d other tha event, the N	l ou	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	OF HEA Maiden Surnai		
ylan	should be file n and Mental I 7 is marked o raumatic eve	유	WILMORE HORSLEY				EDNA	F. MORG	AN	,	
Maryland	0 = 2 =		19a. Informant's Name/Relationship (Type EDWARD HORSEY (NE	· · · · · · · · · · · · · · · · · · ·		g Address (Street ar ALAHAD CT					Code)
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Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Fu eral Service Libersed	ONATHAN D. HI		. Name and Address					P.A. AND 21217
			23a. Part 1. Epper the disease, or complic shock, or neart failure. List only one	ations that caused the death.	Do not ente		_				Approximate Interval Between
-4	nysician/		Immediate duse (Final disease or condition	Acut 1	My	loano	us L	euVom	14	- 1	Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a consequen	10 -01):	0)
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876	ificate ng phy as the	Med	IF FEMALE:								
Box 687	th cert tendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal c	death 3					Date of delive	
. Bo	ne deat / the at ched fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of dea g ☐ Unknown	ath 5 L	Other (specify)				Month	Day Year
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al F	ian: T srtifica ctor, p		25. Was case referred to medical examiner?			26. Plac	ce of Death (Ch	1 L Yes	2 No	1 L Yes	2∠ No
Ξ	hysic his ce	욘	1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF		t 3 DOA Other	: 4 ☐ Nursing	Home 5 Resid	dence 6 Ot	ther (Specify	, flospia
ou o	inding Path. r: After te funera	Certificate:	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury : work? M 1 🔲 Y		28d. Describe h	ow injury occu	rred	V
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. to the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
_	Hospita 4 hours Funeral ted fille	Medical	29a. Certifier 1 Certifying Physici (Check Medical Examiner	an: To the best of my knowled On the basis of examination a	lge, death o	ccured at the time, of gation, in my coinion	date and place,	and due to the ca	use(s) and man	iner as state	d.
	o the	Ĭ	only one) 3 Certifying Nurse F 29b. Signature and title of certifier	Practioner: To the best of my k	nowledge, d	eath occurred at the	time, date and p	place, and due to th	e cause(s) and r	manner as sta	ated.
	F ≥ F 0		George He many	W) Com			5A44	9	29d. Date sign	2 (Nonth, I	Day, rear)
	E		30. Name and address of person who com	pleted cause of death (Item 2)	3a) (Type, Pi	rint) , 2 0 /	0	1			
	5		Course Hours	upi , 140 , 6	701	N. M	ouls	ST. 10	MION	NO	21204
	Stat Registra		31. Date files (4 ath Day 762009	32. Registrar's Signatur	Barks						,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Henry C. Villines, Jr. 9:05p M Dec 2, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Maryland Medical System Baltimore If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 244-60-1970 Director May 9, 1940 69 No. Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c, City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at Director 1 Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country U.S.A 21216 611 Glenolden Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married I Hygiene. other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Scrap permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other the any Injury or other traumatic event, It a once. Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Villines Sr. Easter Hester Villines ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Normal Avenue Baltimore, Maryland 21216 Katie Woods 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/09 Hurdle, No. Carolina Pine Hill Baptist Church Cemetery uneral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) I ⊈Yes 2 □ No signed by the a O. 9 Hinknown 9 Unknown ď. II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate of Vital 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this after death.

I Director: After this d in by the funeral di 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely the F and manner stated. To the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 10434459X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore 22 15 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40013 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 12, 2009 **Physician** Maria Valenziano 12:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8934 Chapel Avenue Ellicott City Howard 8. Date of Birth (Month, Day, Feb. 16, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 💢 F Italy 84 T925 217-40-7312 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show 1 □Yes 2 No Completed by Funeral Director MD Howard Ellicott City the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: I fiem 27 is marked other than "natural", or items 23a or ury or other traumatic event, I'm Medical Examinations to 8934 Chapel Avenue 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosario Vizzini Vincenza Cefalu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pina Culotta Daughter 8938 Chapel Avenue, Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-15-2009 Timonium, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Signature of Funeral Service Licenses 23a. Part T. Enter the disease, or complications that call the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myelodys 0/65+12 **Physician** year resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours efter death.

neral Director: Aft
filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(eV

State Registrar 31. Date filed (Month, Day, Year) **DEC 15 2009**

5regory

Pro Fropowitz
32. Registrar's Signature

2, 601 N. Cardine St, B, Honore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ Month Charles Welk 2009 4:20 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris hospice Baltimore towson 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 XM 2 F Months Hours 219-30-7807 February 9, 1935 74 Director Usual Residence of Decedent 28a-f shov 10a State 10b County 10c. City, Town or Location the Medical Examiner must be notified at Director Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3331 Walford Drive 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 X Married ð Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Supervisor BGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Welk Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marquerite Welk 3331 Walford Drive, Dundalk, Maryland wife Baltimore, ECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of December 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cardens of Faith Cemetery 15, 2009 Rosedale, Maryland 21. Fignature of Funeral Service License Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, Maryland 21222 nuthones 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. INTRACEREBRAL HEMORRAGE Medical resulting in death) Examiner CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical pe SB use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown been signal Completed 1 Tyes LOUIS WELK 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2X N Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 2 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural 5 Pending work's 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JONES,

15

Ionth, Day, Year,

2300 DULANEY VALLEY RD.

egistrar's Signatu

TIMONIUM, MD 21093

09-09630 Elaine Joyce Walker	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	
1- R	For State Certificate of Death Reg. No. egistrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day	2009 40015
Medical Examiner	Elaine Joyce Walker December 10, 20	009 2305 hrs County of Death
1	20 Breton Hill Road Apt. 2B Ba	altimore County
	5. Social Security Number 3 6 6 - 6 0 - 1812 6. Sex 1 Months Days Hours Min. 3 / 24 / 53	D/YYYY) 9. Birthplace (State or Foreign Country) M I
A and	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 Yes 2 No
with the Maryland us 23a or 28a-f show any be notified at once.	20 Breton Road-Apt. 2B 21208	en of What Country? USA
or items 23	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. White
2 hours afte "natural"; LExaminer	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Leave the provided of	ospital
Baltimore, MD 21215-0036 bennit. Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natu injury or other traumatic event, the Medical Exan To Be Completed	T7. Father's Name (First, Middle, Last) Hjalmer Holmstrom Verna Niemela	Surname)
MD 212 2 should be h and Ments 27 is mark rumatic even	19a. Informant's Name/Relationship (Type, Print) Vanessa Walker/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, Cit 20 Breton Hill Rd, Pikesvil	le,MD 21208(2B)
MOFE, Pages I and nent of Healt ant: If item or rother tran	2 Cremation 3 Removal from State Crematory or other place) Mt. Carmel Cem. 1 Z Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Ba	
	21. Signature of Fun al Service (1) See 22. Name and Address of Facility Hari P. Clo 5126 Belair Rd, Balt., MD	21206-5105
Physician /Medical ~xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho failure. List only one cause on each line. Immediate Cause (Final disease a. Diphenhydramine intoxication	ck, or heart Approximate Interval Between Onset and Death
Xammer	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
niner	if any, leading to immediate Due to (or as a consequence of):	
couted and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	d. Date of delivery Month Day Year
b, P.O. Bo ires that the deal ires signed by the all d be detached for	Part II. Other significant conditions contributing to death but not resolving in the disease given in	use contribute to the cause of death? No 3 Probably 4 V Unknown
of Vital Records, F ag Physician: The law requires ther this certificate has been sign meral director, page 2 should be n: To Be Completed I	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
I Rectificate or, page	25. Was case referred to medical 26.Place of Death (Check only one)	No 1 Yes 2 No
f Vital Physician or this certi	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Reside	ence 6 🗸 Other: Scene
n of Viding Physical	27. Manner of Death 1 Natural 5 Pending Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28c. Injury at Work? 28d. Describe how injury 28c. Injury at Work? Subject in	gested diphenhydrami
Division o sprital or Attending hours after death neral Director: After filled in by the fune Certification:	3 X Suicide 6 Could not be determined determined (Specific) residence	20 Breton Hill Rd esville, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) at (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	nd manner as stated.
Med Signature	29b, Signature and title of definier	Date signed (Month, Day, Year)
	Kunll (17) N(1)	cember 11, 2009
10 pers	30. Name and address of persub the completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	THE TOTAL PROPERTY OF THE PROP	OCWE

			For State Registrar	State of Ma	•	epartment of learning			iene eg. N2009	40016
			Decedent's Name (First, Middle, Las	t)		- Crimouto Gr		2. Date of Deat	h	3. Time of Death
5	Physicia /Medic		Delores Phy	lis Wr	ight			December	Day Year 13 2009	1146 PM
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5	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
ores	Maryl	tor	MD N/A	Δ	Baltin					1 ¥ Yes 2 □ No
19/0	th the or 28a e.nctfl	Jirec	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	untry?
1	n 72 hours after death with the Maryland "netural", or items 28a or 28a-f show solical Examirar must be notified at	Funeral Director	123 W. 29th St.				21218		JSA ————————	
	items items	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?	Ever in U.S.	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
37	hours after ural", or ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 x No	Specify:		Specify Bla	ck
	72 ho 'netur	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of wo	rking	16b. Kind of Business/I	ndustry
Z 2	within lene. then "	dwc	Elementary/Secondary (0-12)	College (1-4or 5)+)				ominata II	
	be filed withi ntal Hygiene. ed other ther event, It a M	Be	17. Father's Name (First, Middle, Last)	N/A_	Mur	sing Ass:		me (First, Middle, I	Private H Maiden Surname)	OII/E
a S /lan	uld be Wenta rrked tic ev	To B	Leslie E	Bundy			Thelma	a Wils	son	
升、人とかかっなS Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiera Important: If item 27 is merked other then " eny Injury or other traumatic event, It a Ma. once.		19a. Informant's Name/Relationship (7 Dorothy Weeks/s	Type.Print)	I				; City or Town, State, 2	, ,
人とかめた more, Mar	1 and Healt Iem 27		20a. Method of Disposition						20c. Location - City or	
₹ mom	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	King Mo	isposition (Name of crematory or other pla emorial I	PK 12/1		odlawn,	
.⊬ alti	permit. Departm Importa eny Inju		21. Signature of Funeral Service Licen	<u></u>		22. Name and Addr	ess of Facility Be	everly [). Cromar	t. i.g.
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О.	e dea the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a		5 Other (specify)	icy		Month	Day Year
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	5		30. Name and address of person who	completed cause of d		/pe, Print)	, ,,	/ / /	lecember 1 Baltim	
			Patrick T	MCGIN	rar's Signature	Di Sino	ai Hosp	ital of	- Baltim	ore
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			For State Registrar	State of Maryla		artment of He <i>rtificate of D</i>			ne 2009	40017
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	/Medio	0.00	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or L	ocation of Death	12	4c. County of Death	
			Good Samaritan H 5. Social Security Number 6.		s. last birthday)	Baltimore	If Under 24 Hrs. 8	Date of Birth	9 Rint	nplace (State or Foreign
ŀ	Funeral Director		239-32-9881	1 M 2□F	81 Yrs.	Months Days	Hours Min.	(Molth, Day, Y) 04/23/14	28 Con	AC
	yland low at		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	ne Mar 8a-f sh ptified	ctor	MD	ck	saltimo			10-	Cikings of Miles Co.	1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hyglene. Iteath and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	915 North Hil	1 Road		10f. Zip Code 2/2/	8	109	. Citizen of What Co	untry?
	er deat items ? ner mu	uner	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci , Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
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Maryland	12 shout A and A is main		19a. Informant's Name/Relationship	(Type. Print) S Wife	19b. Maili	ing Address (Street a		FiMOR		(ip Code)
	s 1 and 2 of Health item 27		20a. Method of Disposition	206	. Place of Disponentery, cre	osition (Name of ematory or other place	, Da		oc. Location - City or	Town, State
Baltimore,	permit. Pages Department of I Important: if its any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify) (7	urrison	FOYEST 2. Name and Address	12/17/	109 00	vings Mil	Is Maryland
Bal	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Lic	Hrune	· Vé	aughn C.	Freene F.	S. Hall	Limore, Ma	ad vulund HI12
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or Vital Records,	The lav	Completed	CITY STINGE	KUNC J	<u> </u>	0		autopsy	prior to	completion of cause of
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7 Or	ding Phys .r After this funeral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Matural 5 ☐ Pending	1 ☑ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time	THE OLIDON	4 Indising nom	e 5 ☐ Residen 3d. Describe how	ice 6 Other (Spe v injury occurred	спу)
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Οį	ospital or A hours after uneral Directly filled in by	Certif	4 ☐ Homicide determine	building, etc. (Spe				City or Town,		
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DHMH 17 Rev 1/2001

WILLIAMS, RAYMOND

ase type of Film in place. g898 12-15-09 ye amend item. I per doc g898 12-15-09 ye State of Maryland Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar 40018 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 420 Mary Elaine Ward DECEMBER 8:46 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL HARBOR BALTIMORE None Social Security Number 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Months Days 216-20-4654 Mary Land Director Usual Residence of Decedent 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🚱 🔽 No Maryland Anne Arundel <u>Glen Burnie</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6509 South Charter Road 21061 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? v Never Married 2 Married Black, White, etc ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Teacher Anne Arundel Count is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John J Ward Elizabeth Elaine Gillaspey 19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steele Nicholson Gillaspey 225 Broadway SanDiego California 92101 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 ☐ Burial 2 XX remation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) GreenMount Crematory Dec 11, 2009 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland ignature of Funeral \$ 22. Name and Address of FacMMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPSIS Fuysician disease or condition DAYG Medical resulting in death) Due to (or as a consequence of): Examiner PHEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and defacted for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\text{ No} \) 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has , page 2 autopsy perform 2 No 1 Yes 25. Was case referred to medical сотрете filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death
Natural
Accident Certificate: 28b. Time of 28c. Injury at iniury 5 Pending after death.

Director: Aft 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gentifying Nurse Practiciner: It is best of my knowledge death accurred at the line date and place, and due to the cause(s) and manner stated (Check within 2 To the I ally and sat the time date and plane, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, BELINKA, MD SE BGE DDI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITA 3001 S. HAMOVER STREET State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>09</u> Physician/ Month Susan Wade Dec. 13 8:05 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 407 South Gilmore Street Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth **Funeral** 1 □ M 2**X** F Days Months Hours Min 214-38-6089 **Director** 76 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 407 South Gilmore Street 21223 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oscar Carpenter Lacev Snow Keester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. Sharon Ballinger/ Granddaughter 1816 Dover Street Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1-2 Years Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 X No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🐧 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Frontioner. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37572 14,7009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 25 Main Street Suite 200 Reisterstown, Maryland 21136 Jeffrey Zibell M.D 31. Date filed (Month, Day, Year) 32. R strar's Signatu State Registrar

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~.	Medio Examin		4a. Facility Name (if not institution, giv			4h City Town o	r Location of Death	Decembe	4c. County of Dear	
H.	Examin	er	Ellicott City Health		tation	Ellicott			Howard	
	Funeral Director		214-24-9367		(In yrs. last birthday, 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr. 26	9. Bir 1927 Mary	thplace (State or Foreign untry) / Land
	nd now	Ļ	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation		·		10d. Inside City Limits
	larylar 3a-f sl ified	Director	Maryland Howard	,	Ellicott	City				1 ☐ Yes 2 🛭 No
	the N	اقا	10e. Street and Number	1		10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23a	Funeral	3000 N. Ridge Roa	ad		21043			United St	tates
920	flied within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖔 Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		. Was Decedent of HIf Yes, specify Cub.	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
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imore	- p # 2	-	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Disp cemetery, cri Metro Cr	ematory or other pla	^{∞)} Dec. 200	12, 19	20c. Location - City or Baltimore,	
Balt	permit, Page Department Important; Is any injury or once.		21. Signature of Funeral Service Lice		ice Iser	22. Name and Addre	ss of Facilit ${\tt Cren}$	nation S	ociety of Nore, Maryla	Maryland,Inc. and 21228
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State Registrar

d 1000 / 31. Date filed (Month, Day, Year)

			for State Registrar	State of Maryland	/ Depa <i>Cer</i>	rtment of F t <i>ificate of</i> .	Health and <i>Death</i>	Mental Hy	gien Reg. N		40021
	Observator		1. Decedent's Name (First, Middle, Las	T . 1 .				2. Date of De		ay Year	3. Time of Death
	Physici /Medic		HERMAN W	EDERHAKE.	JE					10, 2009	06:00 PM
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	ath	40	c. County of Death	
_			230 Maple Avenu			Glen Bi		- 1		Anne Aru	
	Funeral		5. Social Security Number 6. S	П м 2П Е	st birthday) L Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mir	n. (Month, Da	ay, Year	r) Coui	
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	r 28g	Director	10e. Street and Number	dider oo. or	cii bui	10f. Zip Code			10g. C	itizen of What Cour	ntry?
	th wit		230 Maple Avenue				21061		Ţ	United St	ates
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.))-	14. Race - Americ Black, White,	
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Ö	filed I Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			rocery	18. Mother's N	ame (First, Middle	, Maide		56
Maryland 2	lid be lenta ked ic ev	To B	Herman Wederhak	e. Sr.			E	mma Uhl	ik		
ary	shou and M s mai	-	19a. Informant's Name/Relationship (7		19b. Mailing	Address (Street				or Town, State, Zip	Code)
Σ	and 2		Mr. Howard A. Pala	mer, Jr./Nephew	230	Maple A	lvenue	Glen Bu	rnie	e, MD 210	61
ore	of He		20a. Method of Disposition	20b. Pla	ce of Dispos netery, cremi	ition (Name of atory or other place	ce)	Date	20c. l	Location - City or To	own, State
Ĕ	Pag ment ant: I		f Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemovai from State		rk Cem.		16/2009	Bal	Ltimore,	Maryland
saltimore,	permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ithe ODEs.		21. Signature of Funeral Service Licen	see	22.	Name and Addre	ss of Facility S	ingleton	Fur	neral & C	remation
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5	Phys r this ral dii	٦.	1 Yes 2 12 No 27. Manner of Death	1 □ Inpatient 2 □ Ei	R/Outpatient 8b. Time of	3 LI DUA	4 ∐ Nursing	Home 5 Resi		6 ☐ Other (Special	fy)
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vision	Atten deal ctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, stree		111	28f. Location (Street a	and Number or Rura	al Route Number.
S	al or	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or To	wn, Sta.	te)	
	To the Hospital or Attending Physician: The law requires that the within 24 hours affect death. To the Funeral Director: Affect this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my knowl niner: On the basis of examination	edge, death	occurred at the ti	me, date and pla	ce, and due to the	cause	(s) and manner as	stated.
	the hin 24	Medical	one)	and manner stated.							
	5 ≥ 5 0		29b. Signature and title of certifier	10 500		29c. Licens			29d. D	ate signed (Month,	Day, Year)
•			- cech & F	verna 140			21336			12/11/0	
	6X1		30. Name and address of person who of	completed cause of death (Item 2	:3a) (Type, P	TCHE H	WY SV	m=134	PAC	ADENA M	21122
	Sta	te	31. Date filed (Month, Day, Year) 1EC 15 2009	32. Registrar's Signatur	re	6		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 1-2		
	Registra	ar	AFC TO SAMA	Deneura B. A	Bekar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Clinton Waite 7:45 P M 2009 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Aspenwood Senior Living <u>Silver Spring</u> Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Year) 017-16-1968 **Director** 90 Nov Massachusetts Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo Montgomery 1 Yes 2X No MD Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14400 Homecrest Road #235 20906 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2X No should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. 1942-44 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Waite Eva Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 13509 Winding Trail Court Silver Spring, MD 20906 Linda Maurano/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/14/09 Woodbine, MD 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Brain Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l ; page 2 s performed After this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 🗌 Yes 2 XNo မ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No М Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the it 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mnaine December 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gov)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

5 2009

Ata Motamedi, M.D. 17904 Georgia Avenue Suite 304 Olney, MD 20832

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) DECEMBER Physician/ Elizabeth Beatrice Young Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MOSPITAL OF BALTIMORE BALTIMORE CITY 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** 05 07 1 □ M 2√□ F Min. Director MD 213-16-672 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 72 hours after death with the Maryland Director Baltimore 1 X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21211 U.S.A. 3855 Greenspring Ave or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Black 3 XWidowed 4 Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
amy injury or other traumatic event, the Medic 41
once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. City Schools 12th grade 5yrs+ Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Cook John Strong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Bolton Place, Baltimore, Md 21217 Gary Boardley Sr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/09 Arbutus, Md Arbutus Memorial 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Signa ve of Funeral Service Licensae Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final MEART FAILURE - EXACERBATIO Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 \ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ELEVATION MYOCARDIAL 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 After this certificate har funeral director, page To the Hospital or Attending Physician: The 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ♣ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident
Suicide Investigation
6 Could not be within 24 hours after death

To the Funeral Director:
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address person who completed cause of death (Item 23a) (Type, Print) MUSPITAL OF BALTIMORE State 15 2009 Registrar

DHMH 17 Rev 7/2009

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AS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ZEPP Month ERNON 10:55 AM LUTHER 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death WESTMINSTER GOLDEN LIVING CENTER CARROLL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. 1 X M 2 □ F Months Hours 37 215-16-628 EB 201922 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No CARROLL WESTMINSTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA WASHING-TON ROAD 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 197es 2 No 1913 If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: WHILE 1946 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARPENTER CONSTRUCTION 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZEPP MARGARET BROTHERS JEORGE

Physician

/Medical

Examiner

10a. State

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Funeral Director

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Completed

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2

Funeral

Director

th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evantiner must be notified at

Physician /Medical Examiner

The law requires that the death certificate be execute ysician and e burial-trans physician the use as for signed by the a d be detached for should ! cate has by page 2 s

this certificate

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Records,

of Vital

Division

Physician/Medical Examiner Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be Medical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

12 Natural
2 Accident

3 Suicide

4 ☐ Homicide

19a. Informant's Name/Relationship (Type. Print)

5 ☐ Other (Specify)

MICHELE

4 Donation

Immediate Cause (Final

disease or condition resulting in death)

20a. Method of Disposition

1 Burial 2 Cremation

21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or som shock, or heart failure. List only

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

28a. Date of Injury (Month, Day, Year)

OAL

ariosa

(or as a consequence of):

Due to (or as a consequence of):

8

20b. Place of Disposition (Name of cemetery, crematory or other place)

6028

TER

3 Removal from State

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery Month Day

SYKCSVIlle MO

ELDERS BURGINO 21784

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 2 1 No 1 ☐ Yes 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 No

26. Place of Death (Check only one)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21764

22. Name and Address of Facility JN Zum BNN EH & MON Co.

HILL

Date

SYKESVILLE RD

RO40

12/14/2004 WINFIELD, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

who completed cause of death (Item 23a) (Type, Print) mp 68

Hospital:

15

egistrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State

Registrar

09-09652		Please Type	or Print in Black	Indeli	ble In	k. Ensur	e All Co	opies Ar	e Legi	ble.			1
Robert Wayne Zo		- For State	of Maryland / De	partme <i>ertifica</i>			id Menta	al Hygier		. N o.	20	09	4002
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,La							e of Death	Dav `	Year	3. Time of	
Medical Examir		Robert Wayn							ember	12, 2009		0013	ars
1		 Facility Name (if not institution, gi Upper Chesapeake Medi 			4	Bel Air	r Location of	Death		Harfor	nty of Deat rd	.n	
Funeral		5. Social Security Number 6. 5			hday)	If Under 1 Yea				(MM/DD/Y)	Carri	rthplace (Sta	te or
Director		218.74.2224	M 2 F 4	9	Yrs.	Months Day	ys Hours	Min. 06	.20.	1960	Co	ountry)MD	
'n	-	Usual Residence of Decedent 10a. State 10b. County	1100 (City, Town	or Locatio	in.						10d. Inside	e City Limits
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yłand a-f sh	Funeral Director	10e. Street and Number				10f, Zip Code			100	g. Citizen of	What Co	untry?	
or 28	jre	2801 Clayton	Road			21085			Ţ	J.S.A			
with the Marylar ns 23a or 28a-fs	필	11. Marital Status	12. Was Decedent Ever i	n U.S.		Decedent of H	ispanic Origi					erican Indian,	Black,
leath r	nue	1 Never Married 2 Marrie	Armed Forces?	lo	l If Ye	s, specify Cuba	an, Mexican,	Puerto Rican,	etc.)		Vhite, etc.		
after c	J.	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:			Yes 2 🗙 N					_{ify:} Wh:		
natur (Xami		15. Decedent's Education (Specify		i) 16a.	Decedent during mo	's Usual Occup ist of working lif	ation (Give k fe. DO NOT t	ind of work do use retired)	ne [16b. Kind o	f Business	s/Industry	- 1
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5+)	As	ssem	bler				MRAS	3		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	E	17. Father's Name (First, Middle, Las	st)				18.Mother's	Name (First,	Middle, M	aiden Surna	ame)		
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21; ould b d Men s mar		19a. Informant's Name/Relationship				Address (Stre							
MD od 2 shouth and m 27 is aumati		Suzanne Zebac	k/Wife		2801	Clay t	on Ro	oad, 、	Jopp	a, MI) 2 <u>1</u> (085	<u> </u>
re, s Lam fillea friten		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State			tion (Name of c er place) ke Cre		12.1					
Page nent o ant: or oth		4 Donation 5 Other Speci	¢		_							•	
Baltimore, permit. Pages 1 ar Department of Iles Important: If iter	Ш	21 Signature of Funeral Service Lic	ensae Mo	3/58	22. N	ame and Addre	ss of Facility	CAFA/	tep	nen 1). Lo	onrma	nn, PA
		23a. Part I. Enter the disease, or cor											mate Interval
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xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen		erosc	rerotio	e card	Tovasc	ulai	uisea	.se	+-	
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68760, certificate be nding physic se as the bur	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of								te of deliv	-	Year
68 certiff	ian	past 12 months?	1 Live birth Pregnant at time	af ala akk	-	tal death 3 ner (Specify)	3 Ectopic	pregnancy		Mor	iui	Day	Teal
Box e death c the atten	Physici	1 Yes 2 No 9 Unkno			3 <u> </u>	ner (opeary)							
b.O. B that the d red by the detached		Part II. Other significant condition	s contributing to death but	not resultir	ng in the L	inderlying caus	e given in Pa	irt I.				to the cause	
P.O. ires that the signed by the detache	d by							<u> </u>				robably 4	
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1 of Jing Ph After t funeral		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b	Time of I		njury at Work	,	Describe I	now injury o	ccurred		
sion ttend death. ctor: y the f	atic	2 Accident Investig	ation				Yes 2		t continu (Ctroot and h	lumber or	Pural Poute	Number, City
Division of Vital Records, ours after death. Division Attending Physician: The law require death. neral Director: After this certificate has been sifilled in by the funeral director, page 2 should b.	Certification:	3 Suicide 6 Could r		At home,	rarm, stre	et, factory, offic	e building, et		or Town, S		AGUIDEL OL	Nurai Noule	ramber, only
EJ e n bi		4 Homicide	ician: To the best of my kno	udades d	noth coo	rad at the time	date and nic	and duo	to the caus	e(s) and m	anner as s	stated.	
To the Hos within 24 h To the Fun	Medical		ner:On the basis of examinat	wieage, a tion and/or	investiga	tion, in my opin	ion, death oc	ccurred at the	time, date	and place,	and due to	the cause(s	s)
To the within To the compl	Med	29b. Signature and title of certifier	and manner stated.			29c. Lice	ense number			29d. Date	signed (Month, Day,	Year)
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To the Hospital
within 24 hours a
To the Funeral
completely filled

Theodore M. King, Jr., MD. State 31. Date filed (Month, Day, Year) Registrar

Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

OGME

December 12, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Antone Charles Zuber 8:45 AM 2009 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □XM 2 □ F Months Days Hours Month, Day, Year) 715/1912 North 97 Director 214 36 9287 Yrs Dakota Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Maryland Aberdeen ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 37 Raymond Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 1 9 3 4 − 5 5 Year or Dates! 11. Marital Status 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Soldier U.S. Army Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Zuber Frances Wojcek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Willard (Daughter) 2306 Calvary Rd, Bel Air, MD 21015 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place
Arlington Nat 1 20a. Method of Disposition 20c. Location - City or Town, State 1 $\!X\!$ Burial 2 $\!\Box$ Cremation 3 $\!\Box$ Removal from State 2/9/2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral service Ligenses 22. Name and Address of Facility
Tarring-Cargo
333 S. Parke o Funeral Home, P.A. St, Aberdeen, MD 21001 hanus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🗶 No Other: Certificate: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending Accident Investigation Μ 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 😿 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 2009

DECEMBER

JONES. CRNP 31. Date filed (Month, Day, Year) State DEC 15 2009

2300 DULANEY VALLEY RD.

sstof person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

Registrar

		Please Type or Pri State of M		ck Indelible Ink. Department of H			_	
	•	1 _ State Registrar	-	Certificate of L	Death	Reg. No	2000	1.0027
		Decedent's Name (First, Middle, Last) A	1/11	<i>t</i> -		e of Death	2003	3. Time of Death
hysici: /Medic		MARCARET M.	Itibi	ret-seen		ienber	10 2009	1200 PM
xamin		4a. Facility Name (If not institution, give street and number	wsing t	tone Roc	Location of Death	10	County of Death	nery
ineral rector		136-18-7067 1□M2XF	ge (In yrs: last I	birthday) If Under 1 Year Months Days	Hours Min. 8. Date (Mo. Jun	e of Birth birth, Day, Year e 3, 19	9: Birth Cour New	place (Statefor Foreign htry) Jersey
MC ##		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	<u> </u>		1	0d. Inside City Limits
-f sh	ţ	Maryland Montgomery	Ro	ockville				1 XYes 2 No
7 28a	irec	10e. Street and Number	1	10f. Zip Code		10g. C	itizen of What Cour	ntry?
23a o	Funeral Director	602 Northcliffe Drive		20850		Uni	ted State	es
ems ?	ner	11. Marital Status 12. Was Decedent Armed Forces		13. Was Decedent of Hi	ispanic Origin? (Specify Ye n, Mexican, Puerto Rican,	s or No-	14. Race - Americ	can Indian,
ral", or ite Evamine	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🏋 No	Specify:	610.)	Specify: Wh:	ite
uatr dice	ete	15. Decedent's Education (Specify only highest grade completed)	16	6a. Decedent's Usual Occupa (Give kind of work done of	during most of working	16b.	Kind of Business/In	dustry
t, the Me	Completed	Elementary/Secondary (0-12) College (1-4or 12	5+)	Secretary)		anking	
even	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First,	Middle, Maide	n Surname)	
narke	2	Campbell McCall			Elizabeth	Irving	,	
7 Is r traur		19a. Informant's Name/Relationship (Type. Print)		9b. Mailing Address (Street a				
em 2		Nancy Allmang / Daughter 20a. Method of Disposition	_	02 Northcliff			, Marylar Location - City or To	
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		of Disposition (Name of tery, crematory or other place and Veterans Ceme	tery 14, 2009	Cro	wnsville	, Maryland
mpor any ir		21. Signature of Funeral Service Licensee	W01005	Robert A. Pur	ss of Facility nphrey Funeral	Home/Roo	kville, In	c.
_ 10 01	-	23a. Part 1. Forter the disease, or complications that cause	M01305	300 West Mon	tgomery Avenue,	Rockvil	le, Marylar	ad 20850-2805 Approximate
sician edical miner		shock for heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or as	line.	e to t	nvive			Interval Between Onset and Death
sician and burial-transit	al Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a	s a consequences					
phys the	dic	d						
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica		e of pregnancy 2 ☐ Fetal dea at time of death	ath 3 Ectopic pregnancy	у		23d. Date of deliv Month	rery Day Year
signed b	by	Part II. Other significant conditions contributing to death	but not resulting	g in the underlying cause give	en in Part I. 23		1/	the cause of death?
peen	etec	3		·····			7 -	
icate has	Completed					la. Was an autopsy performed? □Yes 2 XII	prior to co death?	opsy findings available ompletion of cause of
recto	Be	25. Was case referred to medical examiner?		Outpotiest ST DOA Othe	26. Place of Death (Che			
After this funeral di	tion: To	27. Manner of Death 1	jury 28t	b. Time of linjury 28c. Injury Work	y at 28d. D	Residence escribe how inj	6 ☐ Other (Specury occurred	ify)
Director: d in by the	Medical Certification:	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, etc. (Specify)	farm, street, factory, office	28f. Lo	cation (Street atty or Town, Sta	and Number or Rui ite)	al Route Number,
Funeral etely fille	dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner sand manners	t of my knowled of examination stated	and/or investigation, in my o	me, date and place, and du pinion, death occurred at t	ue to the cause he time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To the	Me	29h Signature and title of certifier		29c Licens	e number 113971	29d. [Date signed (Month)	Day, Year)
		30. Name and address of person who completed cause of	death (Item 23	a) (Type, Print)	lolecular	D, #20	1 Rock	ville, ind 850
Sta Registr		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	bertel				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 13, 2009 4:40 pm **Physician** Della Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Futurecare Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 11/15/1925 Birthplace (State or Foreign Country)
 TTD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 062-44-7940 1 □ M 2√2 F 86 Yrs. VA Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits t be notified at 10b. County MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1000 Gilmore Street 21217 USA ral", or items 23a Examiner must b Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 **N**O Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ➡ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Service / ~ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie M. Johnson Is marked Harvey Moses ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traionce. 42 Talbott Street #A, Baltimore, MD 21225 Angel Copeland / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 12/16/2009 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCULAR DEMENTIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 12-15-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMA REISTERSTOWN 210 CENTER DRIVE BUSINESS 32. Registrar's Signature 31. Date filed (Mount) Day (Par) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BECKER 11080 AM L ENORE DECEMBE 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANDAUSTOWN BALTIMORE LEVIER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth 5. Social Security Number 04/18/1931 Months Hours 1 M 2 F NY 114-24-7197 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 🕅 No BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11 SLADE AVENUE, USA #506 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SHERMAN LÁVINSKY SARAH SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 SLADE AVENUE, PIKESVILLE, MD 21208 KENNETH BECKER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MARYLAND VETERANS 12/15/2009 | OWINGS MILLS, MD 5 ☐ Other (Specify) 22. Name and Address of Facility OL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical

Physician

Examiner

Funeral

Director

or 28a-f show

Funeral Director

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanthre must be notified at any injury or other traumatic event, the Medical Evanthre must be notified at appres.

/Medical

10a, State

MD

Examiner

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ons that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final ATHEROGUEROTTE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy al No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Y#s 28a. Date of Injury (Month, Day, Year) 27. Mary er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

or Attending Physician: The law requires that the death certificate be executed as the burial-tran Division of Vital Records, P.O. Box 68760, the attending physician this certificate funeral death. 24 hours a er deal in by the Hospital within 2 the

> State Registrar

29b. Signature and title of certifie

COURT

32. Registrar's Signature

29c. License number

ROAD

29d. Date signed (Month, Day, Year)

RANDAUS TOWN MARYLAND

DECEMBER 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G898, 12/29/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nargaret 051 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland Baltimore Universit If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Director 213-22-1619 Usual Residence of Decede Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 Pres 2 □ No Funeral Director ML) 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Newer Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. <u>۾</u> 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Emory Informant' Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Balto.MD21223 Jun sarence Date 4-2009 20b. Place of Disposition (Name of cemetery crematory or other 20a. Method of Disposition Cemetery 12-14-09 Hanover MD.
Name and Address of Facility Vaughn C. Greene Fukeral Services 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Nat'l Pike, Balto. MD 2429 5151 Baltimore reene 23a. Part 1. Ent 🕡 e disease, or o' mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumoni Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Malnu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S+. Baltimal. Donald R. Sullivan 72 7/201 Greene 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

16 2009

6/01

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3 /2009 CHARLES GARNETT BROOKS 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 212 Sillery Bay Road Anne Arundel Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/31/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 **2** M 2 □ F Months Davs Hours Min. 79 Director 217-26-9474 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show ral", or items 23a or 28a-f shov 1 ☐Yes 2 No Completed by Funeral Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or important paying or other traumatic event, the Medical Evanter or unstituent and page. 212 Sillery Bay Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1948 – Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ▼No If Yes, Give Year or Dates: 1952 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Design Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ <u>Charles Grafton Brooks</u> Beulah Garnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lenker/Daughter 540 Bay Pointe Drive, Montross VA 22520 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/14/09 Baltimore, 21. Signature of Suneral Service Licensee 22. Name and Address of Facility G.J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 01 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any a line 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 △No 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760,

pital or Attending Physician: The law requires that the death certificate be executed ours after death.
eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burnal-transit filled in by the funeral director, page 2 should be detached for use as the burnal-transit To the Hospital o within 24 hours af To the Funeral Di

the Maryland

Baltimore, Maryland 21215-0036

12 State Registrar

Medical

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30) Name and address of person who completed cause of death (item 23a) (Type 455

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monte Medical 4a. Facility lame (if not institution, give street and number Town, or Location of Death Examiner 1+1more Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 KF Yrs. Director amaica dence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Completed by Funeral Director Yes 2 No more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 0. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) ည nant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 21. Signature of Funeral Service Licensee Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death cute Physician/ stroke morte disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Year Day Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate ☐ Yes 1 Tyes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) uno December 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto Md 2,20% 10701 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Physician/ 13:30 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Kaltimore Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕽 Months Hours Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State RaHiMore 10d. Inside City Limits Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 4 Venue 21206 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Hlack 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Nurse Baltimore, Maryland Father's Name (First, Middle, Last မ 1501 Daughter Drive Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Dicensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter 🖬 mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ∗Physician/ Due to (or as a consequence of) disease or condition resulting in death) rator Medical Examine COPD Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SCN 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မြ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Auras Fractioner: To the basis of my knowledge, death obblined at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D0069314 12/15/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Rd, Parkville MD Waltham apati 8813 . Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Georgia C. Butler 3:10 A. December 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health & REhab. Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Year) 05/07/1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 👿 F Months 401 16 6653 95 Kentucky Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State other traumatic event, the Medical Examiner must be notified at Severna Park 1 Tyes 2K No Anne Arundel Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 45 Marnel Court 21146 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. 1 Tyes 2 X
If Yes, Give
Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Hall Callie Raglynd မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 1 45 Marnel Court Severna Park, Maryland 21146 Robert Butler / Son Department of Healt Important: If Item 2 any injury or other once. 20c. Location - City or Town, State Pages 1 ? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State Glen Burnie, Maryland 12/18/2009 4 Donation 5 Dother (Specify) Glen Haven Mem. Park 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lic 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final erebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): nellitus Examiner Diabetes Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) P.O. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð pothy roldism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification December 14 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Road Glen Burnie MD 21061 1. Ambalavanger Registrar's Signature

DHMH 17 Rev 1/200

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. 2 1 1 Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dect. 13, 2009 6:36рм Carl W. Bailey Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Hospice 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □ F Months Days Hours Min. Country) Director 62 Yrs 219-50-1364 April MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 5237 Saybrook RD 21206 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates Marine 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 XNo Specify. Black "natural", 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Driver Brinks Armor traumatic event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important; If item 27 is marked oth
any injury or other treasment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Bailev Mildred Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delnora Bailey/Wife 5237 Saybrook Rd. Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GarrisonForestVetCemDec22,2009OwingsMills,MD Name and Address of Facility
ALVIN B SCRUG
12 F. PRESTON 21. Signature of Funeral Service Lice FUN 23a. Part 1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Mon Medical Due to (or as a consequence) f): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or imjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an this certificate has page 2 autopsy performed? prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 \square Yes P Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 When (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

070

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryland		rtificate of De			eg. No.	009	4003	7
Physic /Med		Milton	Brow	9			Decemb	Day	Year 2009	330 M	
Funera Director	iner	5. Social Security Number 6. S 157 - 07 - 3866	IOR LIVING	ast birthday, Yrs.		10RE f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)6/28/19	Year)	Count	ace (State or Foreigr try) NJ	7
f show	ō	Usual Residence of Decedent 10a. State 10b. County		, Town or L						0d. Inside City Limits	
with the A 3a or 28a-	I Director	MD N/A 10e. Street and Number 7218 PARK HEIGHTS	AVFNUF	BALTI	10RE 10f. Zip Code 21208		1	0g. Citizen of	What Count		
I e., INICAL Y ICALITY A. I.C. 13-0050 S. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		ce - America ack, White, e		_
within 72 hou within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+) 5 +	(Give life.	dent's Usual Occupation It is the control of work done during the control of the	on ring most of workin	ng	16b. Kind of E		·	Ī
lal ylallu 212 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)	BRO			8. Mother's Name	MEDICAL e (First, Middle, Maiden Surname)				
and 2 should leath and Men m 27 is marke	မှ	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street and	d Number or Rura	l Route Number	IEISSNE City or Towr 21015		Code)	
o e 2 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other place)	D		20c. Location	•	wn, State	_
permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service Licen	lu	89	2. Name and Address of REISTER	of Facility SOL STOWN RO	LEVINS DAD, PIK	ON & B ESVILL	ROS.,	21208	
Physician Ledical Examiner		23a. Part1. Enter the disease, or comy shock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death)		el 7	Arom b		r respiratory arre	est,		Approximate Interval Between Onset and Death	
rificate be executed ag physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter under ying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
the death certification of the attending of the death core as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No						23d. Date of delivery Month Day Year		
w requires that the de-	by	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the u	inderlying cause given i	in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes				1
slcian: The law requirector, page 2 should	Completed						24a. Was a autops perforr 1 Yes	y ned? No	prior to con death? 1 ☐ Yes	osy findings available npletion of cause of 2 No	
Jing Phy I. After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	and the second s	ER/Outpatie 28b. Time o Injury	of 28c. Injury at Work?	6. Place of Death 4 Nursing Hore t 2 s 2 No		nce 6 XO	ther (Specify urred	() ()	
oital or Attendurs after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify	")			28f. Location (St City or Town	, State)			
To the Hospital o within 24 hours aff To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Exam 29b. Signature and title of certifier	ysician: To the best of my know inner: On the basis of examinat and manner stated.	wledge, deat ion and/or ir	th occurred at the time, nvestigation, in my opin	nion, death occurr	ed at the time, d	ause(s) and nate and place	e, and due to	the cause(s)	_
× + × +		30. Namey and address of person who o	completed cause of death (Item	23a) (Tyne	DIS						<u>-</u>
Si	ate		BUBMP 2	C35.	Smy on Au	renve	BALTI	more	212	209	_
Regis		0FC 1 6 201	19 /2 my	1. 136	a Rode						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MYRILE BEA BOYD Month **Physician** December /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1 □ M 2 T F Days 235-44-9751 Director 80 Mar 7, 1929 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Director Baltimore 1 ☐Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 Taney Avenue 21225 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 Nidowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Haas Tailoring Clerical Office Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Price Fix Sallie Mattie Fix ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Boyd (Son) 513 Taney Avenue, Baltimore, Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 12/15/09 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Kevin E Fcker 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 237 East Patapsco Avenue, Baltimore, Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Domen **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death Dav Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ sertensio 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 PNo 1 ☐ Yes 2 🖢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes / 2 🗹 No Other: 4 \sum Nursing Home 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. M. nour of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

Box 68760 P.O. Division of Vital Records,

law requires that the death certificate be executed and burial-trar attending physician ed by the signed by the detach has been certificate To the Hospital or Attending Physician: this After death. after death

Director: within 24 hours aft To the Funeral Di completely filled in

with the Maryland

show

"natural", or items 23a or 28a-f shov

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23.
ury or other traumatic event, the Machail Examirer must

permit. Pages 1 Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

as nse ō

3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

29a, Certifier (Check only one) Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Decamber W, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed gause of death (Item 231) (Type, Print) Hospital Drive, Glen Burnie, MD 31. Date filed (Mon 32. Registrar's Signature

State

DHMH 17 Rev 1/2001

09-09053	
Joseph Bradley	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

loseph Bradley	State of Maryland / Department of H 1- For State Certificate of D		e 200	0 1002				
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No.	3. Time of Death				
Medical Examiner	1 1 14	Mon Nov	th Day Year ember 21, 2009	0445 hrs				
	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	4c. County of Death Montgomery					
Funeral			te of Birth(MM/DD/YYYY) 9. Birth	place (State or				
Director		Martha Dava Have Afa	Foreign	ntry) PA				
	Usual Residence of Decedent		VI V					
w any	10a. State 10b. County 10c. City, Town or Location	4	i i	10d. Inside City Limits 1 Yes 2 No				
daryland 28a-f show Lat nee ector	NJ CAMDEN Chepry 10e. Street and Number	H / II Of. Zip Code	10g. Citizen of What Count					
ith the Maryland 23a or 28a-f sho notified at ence	GOG ORLANDO Rd 08034 USA							
with the mas 23a be not	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	Decedent of Hispanic Origin? (Specify Ye	es or No- 14. Race - America	an Indian, Black,				
r death with or items 23 must be no	1 Yes 2 No	specify Cuban, Mexican, Puerto Rican,		سب رسین				
ural", miner	of Dates	es 2 No specify: Usual Occupation (Give kind of work dor	Specify: WH 16b. Kind of Business/In-					
5-0036 ed within 72 hour ed within 72 hour other than "natu the Medical Exant Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most	of working life. DO NOT use retired)	PAPER	_ ′				
within iene.	il TRuc	CK DRIVER		- 0				
	17. Father's Name (First, Middle, Last) 105EPH BRADLEY	18.Mother's Name (First, I		-12 -				
ID 2121 should be fi and Mental J 7 is marked natic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or Rural Ro		-				
e, MD 2 I and 2 shour Health and IN Item 27 is n r traumatic		ORLANDO RO on (Name of cemetery. Date	Cherry Hill No	108034				
2	1 Burial 2 Cremation 3 Removal from State crematory or other		-09 BALA CYL					
드스의문능	4 Denation 5 Other Specify 21. A tyre of Funeral Service Livense	Re [Hi] 11-00	-UT BALA CAL	CYD IA				
Balti permit. Departn Importi injury o	FI	NK FUNERAL HOME, P.A. 26 CRAIN HWY. S., GLEN I	BURNIE, MD 21061					
Physician /Medical	23a. Part I. Enter the dis lase, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac or respira	atory arrest, shock, or heart	Approximate Interval Between Onset and				
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igi g V	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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Sox 6876 death certificate e attending phy for use as the l ysician/M	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregnancy	M onth Da	ау Үеаг				
). Box 68760, the death certificate be the training physicicle for use as the buriched for use as the	1 Yes 2 No 9 Unknown Unknown 5 Othe	r (Specify)						
P.O. les that the igned by the detache	Part II. Other significant conditions contributing to death but not resulting in the unc		Be. Did tobacco use contribute to the					
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Records, I The law requires fricate has been sig , page 2 should be Completed				opsy findings available ompletion of cause of				
tal Rection: The certificate ector, page	05 Western Control of the Control of		✓ Yes 2 No 1 ✓ Yes	2 No				
Vital ysician his cert directo	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: Inpatient 2 ✓ ER/Outpatient :	26.Place of Death (Check only one 3 DOA Other Nursing Home	·					
n of \ding Phy	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury	iry 28c. Injury at Work? 28d. D	escribe how injury occurred					
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Division of Vital Records, pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been sittled in by the funeral director, page 2 should Lecture. Certification: To Be Completed	3 Suicide 6 Could not be determined (Specify)		ocation (Street and Number or Rur Town, State)	al Route Number, City				
Hospit 4 hour 74 hour 124 hour	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the control of t	d at the time, date and place, and due to	the cause(s) and manner as state	d.				
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.							
A Para	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon					
	Mayour Me Shull	O.C.M.E.	November 22, 20	U S				
	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21201	1					
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		·				
Registrar	DEC 16 2009 June A. Jak	<i>e</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 40040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** December Day 12 2009 Robert Saverio Curreri 3:20 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 5, 1934 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthdav) **Funeral** 1 □**y**M 2 □ F Months Days Hours Min. 213-28-9841 75 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director MD 1 □ Yes 2 No Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 Mt. Carmel Road 21120 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev Saverio Joseph Curreri Christina 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Curreri-son 9300 Carney Rd., Carney, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖸 Other (Specify) Entonoment Dulaney Valley 12/17/09 Timonium, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner End stage Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2: this certificate perform 2 **N**O 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manger of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 ☐ Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\sum \) Homicide

Division of Vital Records, P.O. Box 68760

altimore, Maryland 21215-0036

Hospital or Attending Physician:

within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles Manish

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40041 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December [□]13, 2009 7:30 Catalana Ам Dorothy Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 2904 Erie Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 1 □ M 2 🔽 F 208-16-4737 85 Director lune 1924 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2904 Erie Avenue 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. The Man Elementary/Seconday (0-12) College (1-4 or 5+) 12 0wner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wendel Showman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Catalana husband 2904 Erie Avenue; Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem Gardens 12/17/09 Timonium, MD 21. Signature of Finer I Le vice License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause n each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year signed by the a 1 ☐ Yes 2 ■ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 3 No this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 \square Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifies within 2 only one) 29b. Signature and title of certifier 29c. License number Schende D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keom Schendel 9114 Philadel Phia RD, Suite 300 BAGO MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State DEC 1 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	of Maryland / Depa	artment of Hea		2	009 40043
			Registrar 1, Decedent's Name (First, Middle, Last)	06	Tillicate of De		Reg. No-	3. Time of Death
F	Physici		, , , , , , , , , , , , , , , , , , , ,	TE COSENTIN	n	N.	fonth Day	Year 4:00 A M
**	Medio/ Examin		4a. Facility Name (If not institution, give street and no		4b. City, Town, or Lo		4c. C	ounty of Death
) 			Future Care of the Ch	esapeake	Arn	old	An	nne Arundel
F	uneral		5. Social Security Number 6. Sex 1 □ M 2 🗹 F	7. Age (In yrs. last birthday)		Under 24 Hrs. 8. D	ate of Birth Month, Day, Year)	Birthplace (State or Foreign Country)
Di	rector	l	218-46-4010 Usual Residence of Decedent	97 Yrs.		07	//16/191	2 Maryland
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Mary	find s	ţċ	MD Anne Arundo	, I	Pasadena			1 ☐ Yes 2 🗹 No
h the	or 282	irec	10e. Street and Number		10f. Zip Code		10g. Citize	en of What Country?
th wit	23a c	Funeral Director	178 <u>Ri</u> viera Drive		2112	2		U.S.A.
ır dea	tems	nue	Armed F	edent Ever in U.S. 13. orces?	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify) Mexican, Puerto Ricar	res or No- 14 , etc.)	Race - American Indian, Black, White, etc.
III 4 14 15-0030 be filed within 72 hours atter death with the Maryland ntal Hygiene.	tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be notified at	Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☑ Widowed 4 ☐ Divorced Year or I	2 ▼No ive		Specify:		Specific .
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Vial 2 sh h and	item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)					Town, State, Zip Code)
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Dallillor Dermit. Pages Department of	ortan injur	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Gardens	Of Faith	12/14/	09 Balt	imore, MD
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pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury	(or as a consequence of);				
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S e	attending p for use as	N/ue	23b. Was decedent pregnant	tcome of pregnancy birth 2 Petal death 3 [☐ Ectopic pregnancy		23	d. Date of delivery
e dea	he at led fo	Physician/Me	1 Yes 2 No 4 Pre	nant at time of death 5	Other (specify)			Month Day Year
rat th	signed by the a d be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the cont		ndorbijna gover stvar ir	o Doubl	220 Did tohooo usa	e contribute to the cause of death?
do,	signe I be d	by	Constitution of the significant conditions continuing to	T C 1 \	I C C C	TParti, 2	1 □ Yes & Z	
, requ	s peen s should	etec	- COICETO P. I PRO-		01111			
ne lav	has e 2	Completed					4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>.</u>	certificate ector, pag	ပိ	25. Was case referred to medical				□Yes 2□No	1 ☐Yes 2 ☐ No
ysicia	his certifica I director, p	To B	examiner?	Inpatient 2 ☐ ER/Outpaties	Othor	 Place of Death (Che 4 United States 		Other (Specify)
9 6	ter t		27. Manner of Death 28a. Date	·		<u> </u>	Describe how injury of	
endir	or: Af	atic	2 Accident investigation	an, bay, roary		2 □No		
or Attending Physician:	irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined build	e of Injury - At home, farm, str ing, etc. (Specify)	eet, factory, office		ocation (Street and I City or Town, State)	Number or Rural Route Number,
oital o	illedi							
Hos 24 ho	Fund etely f	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the land many one)	e best of my knowledge, deat basis of examination and/or in iner stated.	h occurred at the time, vestigation, in my opini	date and place, and o on, death occurred at	ue to the cause(s) a the time, date and p	.nd manner as stated. lace, and due to the cause(s)
To the Hospital or Attendin within 24 hours after death.	To the comple	Mec	29b. Signature and title of certifier	mor stated.	29c. License nu	ımber	29d. Date :	signed (Month, Day, Year)
F 5	- 0		hosain and		D57:	531		Mer 11, 2009
į	D		30. Name and address of person who completed cau	se of death (Item 23a) (Type,		- 1		, ,
	<u> </u>			, , , , ,	*	ente 200	nill	essible my 2110
	Sta		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	e Alas		1	
	Registra	ar	DEC 16 ZUU9 CO	wer p. 190				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40044 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 8 1 Year **Physician** 674577M December ANN MARIE CRAVENS 12008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E-120 Anne 18mm Baltimore Washington Med Ctr 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Min Hours 217-46-3506 Director 61 12/18/1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in a medical Examiner must not 28a-f. show once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8056 Belhaven Avenue Funeral 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No 2 Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Angel's $\overset{\text{Elementary/Secondary (0-12)}}{11}$ College (1-4or 5+) Kitchen/Deli Staff Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Johnston ပ Dorothy Marie Malamphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Cooper/Sister 388 Riverside D<u>r</u>ive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/09/09 Baltimore. 21. Signature of Suneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA <u>169 Riviera Drive, Pasadena, MD 21122</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760; attending physician Physician/Medical as the IF FEMALE: for use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate Division of Vital 1 ☐Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours aft e Funeral Di etely filled ir Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated rtifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s)

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the I 29b. Signature and title of certifi-

Stat

State 31. Date filed (Month, Day, Year)
Registrar

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland /		irtment of F tificate of D	lealth and M De <i>ath</i>	lental Hygi	ene	09	40045
	S	,	Decedent's Name (First, Middle, Las	t)		-			2. Date of Death	1		3. Time of Death
	Physicia Medic		Martha E		os				Decembe	r 10,20	Year 109	4:05P M
	Examin	er	4a. Facility Name (if not institution, give					Location of Death		4c. County of		
rest "	Funeral		5. Social Security Number 6. S	Hospice (care e (In yrs. løst birt	thday)	Towson	n If Under 24 Hrs.	8. Date of Birth	l Bal	timo	olace (State or Foreign
	Director		215-30-4448	□ M 2 🗓 F		Yrs.	Months Days	Hours Min.	Dec. 31	,1933	Count	
	nd now at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	arylar la-fsl	Director	MD Baltim	ore	Luthe							1 ☐ Yes 2 💢 No
	or 28 or 28 e not	Dir	10e. Street and Number	OI C	Lucite	EL VI.	10f. Zip Code		10	Dg. Citizen of W	hat Coun	itry?
	n with	Funeral	11346 Greensprin	g Ave.			210	093		USA		
	r item iner n		11. Marital Status 1 □ Never Married 2 🏿 Married	12. Was Decedent E Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race Black	- America	
92	o filed within 72 hours after death with the Maryland the Hygiene. A tall Hygiene and the first of the than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes 2 🕅 No	Specify:		Specify:	Whi	.te
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2	iled within Il Hygiene. other tha vent, the N	Be (17. Father's Name (First, Middle, Last)	N/A	V1	.ce .	President 	18. Mother's Name	(First Middle Ma		ty K	oofing
Maryland 21215-0036	d be fil dental rrked tic ev	10	Arthur Lee Bratch	ner, Sr.					Folker			
lary	should and N is ma auma		19a. Informant's Name/Relationship (T)	pe, Print)	19b	. Mailing	g Address (Street a	nd Number or Rura			ate, Zip C	lode)
	and 2 s Health tem 27 other tra		Terry Madigan/Da	ıghter				Ct. Spa				
00.0	- 5 E C		20a. Method of Disposition 1 ☐ Burial 2 🏻 Cremation 3 ☐		cemete	ry, crem	ition (Name of atory or other place	Dec.	11,	20c. Location - 0	•	
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ñ	Departi Departi Importi any inji	9	000		Flagle	Le	emmon Fun O W. Pado	s of Facility neral Home onia_Road	e of Dula	aney Va	11ey	inc.
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- 4	nysician/ Medical	i V	Immediate Cause (Final disease or condition resulting in death)	a	Luna	(ancer				r	Onset and Death
_	Examiner		resulting in death)	Due to (or as a	consequence	3)						·
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	cate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or as a	consequence of	of):						
30	certificate be executed anding physician and use as the burial-transi	edical		d							<u> </u>	
200	certifit inding use as	M/II	ZSD. Was decedent pregnant	23c. If yes, outcome		- a \Box	Fatania anno anno a			23d. Date	of delive	ery
ROX	sician: The law requires that the death certific certificate has been signed by the attending frector, page 2 should be detached for use as	Physician/M	in the past 12 menths?	4 Pregnant at			Ectopic pregnancy Other (specify)			Mont		Day Year
J. :	at the d by th etache	Phy	9 Unknown Part II. Other significant conditions or		ıt not resulting i	in the un	iderlying cause give	en in Part I	22a Did toba	ann una contrib	uto to th	e cause of death?
ນ໌. ທີ່.	res th signer	d by					gon, mg outto gin					pably 4 Wunknown
ord	requi	lete							24a. Was an	24b. W	ere autop	psy findings available
Vital Records,	he lav tte has vage 2	Completed							autopsy perform 1 Yes 2		ior to con eath? Yes	mpletion of cause of
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<u> </u>	Physic this c	မ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient		4 L Nursing Hor		7		Gilchrist
n or	oding tth, tath, tuner	cate	1/10 Natural 5 Pending 2 Accident Investigation	(Month, Day		njury	28c. Injury work? M 1 🔲	Yes 2 No	8d. Describe how	injury occurred		
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	I of the hospital of Affanding Physician: The law requires that the death within 24 hours affar death. To the Funeral Director After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for the funeral director.	Medical	(Check 2 Medical Exami		amination and/o	r investiç	gation, in my opinior	n, death occurred at	the time, date and	place, and due t	the caus	se(s) and manner stated.
-	within To the compl		29b. Signature and tale of certifier	e Prectioner: To the I	best of my knowl	leage, as	29c. License			d. Date signed (
			· Eur	Sula	MD		1 16	8100	1	12	11	109
1	n/		30. Name and address of person who o	ompleted cause of de	eath (Item 23a) (Type, Pri	int)	i.Dalle	C. 2	100 -	a W	10 21201
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	162	>+/>	ulte IIC	13/ 120/	L'inor	1	D DIZUY
	Registra		DEC 16 ZUUS	Denen	B. 190	uko						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #36a配子 Maylang Department of Health and Mental Hygiene 1009

40046 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER DAMARECK 2009 STANLEY 2:56P M Medical 4a. Facility Name (if not institution, give street and number)
NORTHWEST HOSPITAL Examiner 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Director 212-44-6504 0170871946 63 GERMANY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director REISTERSTOWN 1 🗌 Yes 2 💢 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21 SQUIRE COURT 21136 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Specify: Completed 3 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES CELLULAR PHONES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAMARECK ZAVOLEVITCH SONIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 SQUIRE COURT, REISTERSTOWN ,MD 21136 SUSAN SCHER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUND 12/16/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licent REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Olar Physician/ disease or condition Medical resulting in death) Due to (or a\$ a consequence of) Examiner 0 0V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of); 676 Due to (or as a consequence of). resulting in death) Last burialphysiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the upperlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 □/No Other: မ 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier cause (Item 23a) (Type, Pa 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert Victor Dallmus P_M 2009 3:05 December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3 Une | 11, 1916 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1**⊠** M 2□ F Months 93 216-05-8052 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary land Baltimore Parkville 1 TYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd., #117S 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Victor Dallmus Elizabeth Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen R. Dallmus / Son 5412 Willowmere Way, Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other pla Moreland Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/18/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALLHEIMER J. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide No CATE PARTY IN A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Physician /Medical Examiner Box 68760. certificate be Division of Vital Records, P.O. Hospital or Attending death. nours after death 24 hours a To the within 2.

burial-transi and

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Physician/Medical

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Completed

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Certification: To

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2

16 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUSTINE PREIS CRUP 8833 WA

physician

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page certificate

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be rediffed once.

Baltimore, Maryland 21215-0036

completely

DHMH 17 Rev 1/2001

Registrar

8832

32. Registrar's Signature

WALTHER BLUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40048 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Elizabeth Charles Durbano 3:50 PM /Medical December 14 200 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Gwynn Oak Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🖫 F Days Hours 579-66-8280 Yrs Director November 29. 1932 Pennslvvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shor the Medical Examinar is ust be notified at Directo Maryland Frederick 1 ☐ Yes 2 ☑ No Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 335 South Seton Avenue 21727 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23s any injury or other traumatic event, the Waden Examinar, ust any injury or other traumatic event, the Waden Examinar, ust once. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Catholic Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Durbano Del Pizzo ည 19a. Informant's Name/Relationship (Type. Print) Sister/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Greenspring Valley Rd., Stevenson, MD <u>Sr. Patria Hoeflich S.N.D.de N.</u> 20b. Place of Disposition (Name of cemetery, cematory or other place)
Sisters of Notre Dame de Namur Cametery 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/19/200 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Multiple Sciensis
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner Due to (or as a sonsequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Se and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pion 1 Yes 2 No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) the þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed has page 2 s 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred s after dea. "al Director: Afte 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one)

Division of Vital Records, the

> Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) DEC 1 6 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Soboran

2835 Smith Ave Baltimore MD 21209 Swim 32. Registrar's Signature

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Manyland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 2009 DONALD. BEACH 1849 DOOLITTLE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Memoria Easton TA(bot If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □**X**M 2 □ F Months Hours Min. DEC. 2, 1918 NEW YORK 90 Director 118-03-2527 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral UNITED STATES 700 PORT STREET #114 21601 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER **AERONAUTICS** Be permit. Page 1 and 2 should be filed Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARLEY DOOLITTLE NINA BEACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEATRICE DOOLITTLE/WIFE 700 PORT ST. #114 EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION CENTER 1 Burial 2 Cremation 3 Removal from State NOV.13,2009 4 Donation 5 Other (Specify) STEVENSVILLE, MD John R. Merceron per DVR FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST. EASTON, MD 21601

23a. Part 1. Enter the clisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ ASPIRATION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARPIONYOPATHY ISCHEMIC Esque traily list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): g Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) signed by the sid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy is certificate h 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 in 24 hours area control the Funeral Director: Af

Medical

State

Registrar

29a. Certifier

(Check only one

29b. Signature and title of certifier olul Britses

20059487

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 11-11-09

28f. Location (Street and Number or Rural Route Number.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Botsis, MD 219 S. Washington Street Easton, MD 21601

NOV 13 2009

determined

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of De 24 Hrs. Min. 9. Birthplace (State or Foreign Gountry) 8. Date of Birth **Funeral** Months Hours Month, Day, Director or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral items ? death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use paired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ Lwite Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Numbe 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other 5 Other (Specify) 21. Signatur Juneral Service Licenses Name and Address of Facility Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for hear failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset an ... eath Immediate Cause (Final Physician disease or condition resulting in death) veeles Medical Due to (or as a cons Examiner Eugueritially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown the 9 Unknown P.O. been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy pleted filled in by the funeral director, page 2 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 🗆 No death. Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

State Registrar 31. Date file

use of death (Item 23a) (Type, Print)

. Registrar's Si

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stella R. Doetzer **Physician** PEGENBE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore washington Arundel Anne medical cente Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-12-0763 1 ☐ M 2 🗙 🗶 Months Days Hours Min **Director** 4/30/1922 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 협 MD N/A Baltimore City permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f si any Injury or other traumatic event, Its Medical Examiner must be notified. Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 Reynolds Street 21230 **USA** Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify white 3 Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaw Klosek Rosalia Kalinawska ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joseph J. Klosek / Nephew 3601 Greenway, Unit # 307, Baltimore MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cemetery 12/17/2009 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service LicenseeVictor P. Doda, Jr. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRIBLEMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **J**K the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ပ္ 29c. License number Mu pleted cause of death (Item 23a) (Type, Print) and address of person who co AND

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7.58 AM NIEL 12 04 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON HED. CENTER RALTIMORE Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Month, Day Country) Marvland 21534 2969 3 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7709 Lee Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Armed Forces?
1 ✓ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give 1958 Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machania 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than Anne Arundel Mechanical Elementary/Seconday (0-12) College (1-4 or 5+) Community College 4+ Engineering Instrctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ <u> Harry Spalding Edwards</u> Florence Catherine Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael <u>Elizabeth Edwards/Daughter</u> 908 Drive, Gambrills, MD 21054 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) 12/15/09 Crownsville, MD Veterans Cem 21. Signature of Funeral Servic - Icenses 22. Name and Address of Facility G.J. Gonce Funeral Home, 69 21122 Riviera Drive, Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 4 cute Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronor Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 25. Was case referred to medica examiner? æ 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Tes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) d title of certifier 29b. Signature 29d, Date signed (Month, Day, Year) a 36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X GLEN BURNIE BADRO OAKWOOD Rd.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

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Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland		artment <i>tificate</i>			and M	_	giene Reg. No		9	400	153
	Physicia		Decedent's Name (First, Middle, L.)	ast) Mary Ann	Estey		imodio	<u> </u>	·ouiii		2. Date of De	ath	1, 200	1	3. Time of 1	
	Medi Examii		4a. Facility Name (if not institution, gi Montgomery Gene:				4b. City, Town, or Location of Death				Decemb	4c. County of Death Montgomery			I MI	
	Funeral Director		549-42-6373	Sex 1 □ M 2 ♣ F	ige (In yrs. Ias 78	st birthday) Yrs.	If Under 1 Months	l Year Days	If Under 2 Hours		8. Date of Bir Month, Da March I	th y, Year 193	9. E C 6	Birthplac Country	e (State or ornia	Foreign
	e Maryland r 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omery	10c. City,	Town or Loc	i1ver		ing						Inside City	,
	n with the rs 23a or	neral [10e. Street and Number 3701 Dulwick Dri	ive			10f. Zip (906				izen of What 0 ed Sta		?	
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1	Ever in U.S. ? No		Vas Deceder Yes, specif			in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - An Black, Wh Specify: Wh	ite, etc.	ndian,	
Baltimore, Maryland 21215-0036	I within 72 ho ygiene. her than "nat ht, the Medica		15. Decedent's (Specify only highest of Elementary/Seconday (0-12)	grade completed) College (1-4 or 5+	5+)	life. DC	ent's Usual ind of work ONOT use n	done di etired)	uring most	of working	g	Mon	nd of Busines tgomer blic S	у Сс	unty	
yland	ld be filec Mental H arked ot atic even	To Be	17. Father's Name (First, Middle, Last Charles A. Este	эy							(First, Middle, ne McD					
, Mar	nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Judith Bresler/Re	Ys6πa1 ∍presentat:	ive	1071.	5 Char	ter	nd Number Drive	or Rural l e #20	Route Numbe	r, City or 1mbia	Town, State, 2 R, Mary	Zip Code land	1 210	44
timore	:. Page 1 a tment of H tant; If ite jury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State	20b. Pla e Mo	ce of Dispos TEETINET mator:	atory or oth	er place) De	cemb 200	er 14,		cation - City o	Mar	yland	
Bal	permit Depar Impor any in		21. Signature of Funeral S. vice Licer	-	M0019	0 /5:	o/ Wis	cons	sin Av	7e.,	ineral Bethes	da, l	/Bethe C Marylai	sda- hase nd 20	Chev 0814-	y 3 5 01
\	Physician/ Medical	2000	23a. Part 1. Exter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	onia		the mode of	of dying	, such as c	ardiac or I	respiratory arr	est,		Inte	proximate erval Betwo set and De nours	een
	Examiner	JE.	Sequentially list conditions.	b. —	rovasc	ular A	Accide	ent						24	hours	5
W	cuted Ind transit	xamin	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as			_					_				
760 A	ate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequence of):												
P.O. Box 687	he death certificate be executed y the attending physician and ched for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 P No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 L Fetal d	leath 3 🗌	Ectopic pre Other (spec					2	3d. Date of do	elivery Day	Yea	ar
s, P.O	To the hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	d by PI	Part II. Other significant conditions of Chronic Obstruct	contributing to death books ive Pulmor	out not result nary D	ing in the un	derlying cau	ıse give	n in Part I.		.,,		e contribute t			
Division of Vital Records,	law requ	nplete	Inanition								24a. Was a	ın	24b. Were a	utopsy fi		ailable
al Re	sician: The law certificate has b lirector, page 2 s	Be Cor	Pulmonary Hypert 25. Was case referred to medical examiner?					26. Plac	e of Death	(Check o	-	med? 2 K No	death? 1 ☐ Ye	es 2 🗆	No	
ot Vit	g Physic er this ce eral dire	မ	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of inju	ient 2 🗆 EP	Bb. Time of		Other:	4 L Nurs	_	e 5 🗆 Reside		Other (Spec	cify)		
Sion	Attending death. ctor: Affe y the fun	Certificate:	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	oe Diago of Init		injury	М	work?	es 2 🗆 N	lo						
2	piral or y		4 ☐ Homicide determined 29a, Certifier 1 ☒ Certifying Phy	building, etc	c. (Specify)						City or Town	n, State)	Number or Ru		te Number,	
1	thin 24 ho the Fun mpleted	Medical	only one) 3 Certifying Nur	vician: To the best of niner: On the basis of experience of the basis of the practioner: To the	examination ar	nd/or investig	ation, in my ath occurred	opinion, at the t	death occu ime, date a	irred at the	e time date an	d place a	and due to the	Called(e)	and mann	er stated.
ď	8		29b. Signature and title of certifier)			D00	umber 35045				signed (Mont nber 11			
			30. Name and address of person who Philip Henjum, M.	D. 18109	Prince	e Phil		ive	#200	, 011	ney, Ma	ary1a	and 208	332		
	State Registra	~	31. Date filed (Month, Day, Year) DEC 1 6 2009	32. Registra	ar's Signature	how.	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	iene	40054
			Registrar C6	ertificate of Death		eg. No 2009	40004
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Dav Year	3. Time of Death
	Medic	al	Eugene DuWayne Evans,	1	Decembe		11:30 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
an year			Collingswood Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgome	
	Funeral Director		480-12-3401 1 M 2 □ F 87 Yrs.	Months Days Hours Min.	(Month, Day, October	Year) 9. Birth Court 8, 1922 Iowa	place (State or Foreign htry)
			Usual Residence of Decedent		Tocroper	0, 1922 10wa	1
	sho d at	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Montgomery Silver	Spring			1 ☐ Yes 2 🛛 No
	n the taor ben	al D	10e. Street and Number	10f. Zip Code	11	0g. Citizen of What Cou	ntry?
	h wit ns 23 nust	Funeral	3384 Chiswick Court, #51-E	20906		United Sta	tes
	deat riten inerr	Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.0 / 2	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	after al", o	d by	1 Never Married 2 Married 1 X Yes 2 No 1943-	1 ☐ Yes 2 🛛 No Specify:			ite
ş	atura cal E	Completed	47.8	edent's Usual Occupation		16b. Kind of Business In	duata
7.2	an "n Medi	E E	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ting	TOD. KING OF BUSINESS IN	dustry
7	withir giene er th			sman		Appliance S	Store
b	filed al Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, M	aiden Surname)	
<u>Ja</u>	d be Ment arke	ပု	Raymond Evans	Alma Ha	aatvedt		
Maryland 21215-0036	shoul and is m	1 18		ing Address (Street and Number or Run			· ·
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Auburn Avenue, Ro	ckville,	Maryland 2	.0850
Baltimore,	Page 1 ament of Hant of Hant of Hury or ot			matory`or other place) Dece	mber	20c. Location - City or To	own, State
Ħ,	permit. Page Department Important: I any injury o once.					ilver Spring,	
Ba	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee M01305	Obert A. Pumphrey Fune	ral Home/R	ockville, Inc	
			23a. Part 1. Inter the disease, or complications that caused the death to one ten	00 West Montgomery Ave			
	en in contra		shock, or heart failure. List only one cause on each it	contine mode of dying, sacin as cardiae t	or respiratory arres	100	Approximate Interval Between Onset and Death
	Pnysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	10 WIVE			
	Examiner		0450065	.10.			
		ner	Sequentially list conditions, if any, leading to immediate b.		Λ		
/	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	d dement	is		
•	exec ian ar irial-tr	Ě	resulting in death) Last Due to (or as a consequence of):				
9	certificate be executed anding physician and use as the burial-transit	dical	d				
687	artifica ling p	/Me	IF FEMALE:	-		1	
Box	ath ce	ian	23b. Was decedent pregnant in the past 12 months? 1 Use Birth 2 Fatal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
	v requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown				,
0.	law requires that the nas been signed by the s 2 should be detach	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
	uires n sigr ald be	ed b			1 ☐ Yes	s 2 🗖 No 3 🗆 Pro	bably 4 🗆 Unknown
Ö	w req	Completed			24a. Was an		psy findings available
ě	rsician: The law Is certificate has bilirector, page 2 s	шо			autopsy perform 1 Yes 2	ed? death?	mpletion of cause of
<u></u>	ian: T	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check		A NO TES	ZANO
₹	Physic this ce al direc	인	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residen	ice 6 Other (Specify)
0	ding Pl th. After th funera	ate:	27. Manner of Death 1 🛣 Natural 5 □ Pending (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	of 28c. Injury at work?	28d. Describe how	/ injury occurred	
0	tend leath tor: A the fi	iţic	2 Accident Investigation	M 1 Yes 2 No			
Division of Vital Records,	I or Attendated deat Director:	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	id due to the cause	e(s) and manner as state	ed.
V	n 24 h	Med	(Check 2 Medical Examiner: On the basis of examination and/or inveronly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	t the time, date and	place, and due to the car	use(s) and manner stated.
1,	To the vithing to the complete		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	
			27/100	0006243	35	12/14/	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,		Park	1.11/p M	070850
			31. Date filed (Month, Day, Year) 32. Registrar's Stgnature		Lack	1000	0,0
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
		_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Zahina Vasquez Espino Zahira Vasquez Espino 200^{Yea} December Medical 4:05 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) January 29 Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Days Hours Min Director 214-06-1078 82 Panama Usual Residence of Decedent shov 10a. State 10b. County the Maryland 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 28a-f 1 ☐ Yes 2X No Maryland | Montgomery Rockville 10e. Street and Number ö 10f. Zin Code 10g. Citizen of What Country? 23a Funeral 4602 Eades Street 20853 United States permit. Page 1 and 2 should be filed within 72 hours after death Nepartment of Heatth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 ☐ Yes Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Manuel Elias Vasquez Zahida Vasquez Mendez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marta Espino Morales/Daughter 4602 Eades Street, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State cemetery, crematory or other place) December 11, 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2009 21. Signature of Funeral Service bicensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 This Prume M01360 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Interval Between Onset and Death Immediate Cause (Final Fnysician/ disease or condition 4 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on Cause (Disease or iinjury that initiated events sician and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be as the l attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Por 5 Other (specify) Pregnant at time of death Month Year the detached g Unknown g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate ☐ Yes 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death. To the Funeral Director; After 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MaleColar

29d. Date signed (Month, Day, Year)

Rockulle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40056 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HINDA ESTERSON Year Medical 11:33 P M 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Baltimore Singi Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Director 80 Country) Vrs 04730714929 217-24-3342 Usual Residence of Decedent 10b. County 10a. State and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6607 PARK HEIGHTS AVENUE, APT. B-1 **USA** or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Tes 2 X No Specify: 3 Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. 1 Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meagnee. Elementary/Seconday (0-12) College (1-4 or 5+) HEBREW TEACHER JEWISH FDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LEONARD FELDMAN TDA Patient known as FRIFDI ANDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) MORTON M. ESTERSON/HUSBAND Baltimore, 6607 PARK HEIGHTS AVENUE APT. B-1.BALTIMORE.MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 12/13/2009 RANDALI STOWN 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Toling 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician/ Immediate Cause (Final Onset and Death disease or condition resulting in death) Intracranial bleed Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated event resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Day the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? disease artery Coronary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a, Was an performed? Yes 2 No 1 Yes 2 400 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital ည 1 ☐ Yes 2 ☐ No Other 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 2 🗆 No thin 24 hours after deat the Funeral Director; completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) MD RES-000 December 12, 30. Name and address of person w completed cause of death (Item 23a) (Type, Print)

State Registrar Jason

31. Date filed (Month, Day, Year)

u

MD

of Baltimore

Sinai Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40057 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 0058 N Maryland Elli's

4a. Facility Name (If not institution, give street and number) December 8 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 1+ imore 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Fg
Country) Hours Days Months 1 M 2 F 84 Maryland 219-18-2478 Oct 15, 1925 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits Anne Arundel 1 Yes 2XXNo Baltimore 10e Street and Number 10f Zin Code 10g Citizen of What Country? U.S.A. 227 W. Edgevale Road 21225 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Specify. Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Electric Assembly Worker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otis Lindsay Longest Maryetta Lambeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Ravville Road Parkton, Maryland 21120 Maryland Linda Ellis daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □xBurial 2 □ Cremation 3 □ Removal from State Dec. 15, 2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee LONAGO 237 E. Patapsco Ave. Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ute Abd Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 🔲 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 □Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hiury or other traumatic event, the Medicel Experiment must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours af

To the Funeral D

completely filled in

Division of Vital Records, P.O. Box 68760,

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23b. Was decedent pregnant in the past 12 months? □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Š 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 16



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sit

Brooklyn, MD

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40058 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** FINE 2242 PM DIANA nec 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown
If Under 1 Year If Under 24 Hrs. 8. 1 Baltmore North west HOSPITA 5. Social Security Number 8. Date of Birth 11/04/1939 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Min 217-38-0181 70 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐Yes 2 No Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10g. Citizen of What Country? death with 300 SALONY DRIVE, Completed by Funeral #105 21136 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Itel
ury or other traumattc event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P MORRIS SEAMAN RESSIE TINKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD C. FINE/HUSBAND 300 SALONY DRIVE, #105, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 Donation 5 Dother (Specify) MARYLAND VETERANS 12/17/2009 OWINGS MILLS. MD 21. Signature | Funeral Service | See SOL LEVINSON & BROS., INC 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Athoroscleratic Coronary Vascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) P.0. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 20 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 3☐ No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending F Certification: 28d. Describe how injury occurred To the Hospiter c. within 24 hours after death.

To the Funeral Director: After the Funeral Director: After the Funeral filled in by the fur 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005713

Registrar
DHMH 17 Rev 1/2001

State

Randallstone MD

MD 5401 Old Count RJ

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hristone

31. Date filed (Month, Day, Year)

DEC 16 2009

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FRIEDMAN DECEMBER 9 2009 11:15A [™] LESTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1230 CLEARFIELD CIRCLE BALTIMORE LUTHERVILLE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 **X** M 2 □ F Days Hours Min. 079-32-7247 NY 94 06/08/1915 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm I'velical Examination must be not lifted at 1 ☐ Yes 2 💢 No Director MD BALTIMORE LUTHERVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1230 CLEARFIELD ROAD 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 X Married 1 □Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DENTISTRY DENTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRIEDMAN MILLIE LOSS SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is m any injury or other traum once. 1230 CLEARFIELD CIRCLE, LUTHERVILLE, MD 21093 SHERRY FRIEDMAN / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 12/13/09 WOODLAWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lig 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a ld be detached fo P.O. I 1 Tyes 2 Ho 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 | Yes 2 | No 3 | Probably 4 | Unknown After this certificate has been s funeral director, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 □No 1 ∐Yes 2 ☑ No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier weine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Rd no oawe 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month E C 12 Physician 200 FLAX NAOMI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE CITY LEVINDALE HEBREW HOME If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2(□X)F 92 MD 212-01-1616 02/04/1917 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... ary injury or other traumatic events. 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 XNo Director OWINGS MILLS BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 3440 ASSOCIATED WAY, Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KUSHNER MARY ပ REUBEN ROMBRO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 OLD CROWN COURT. BALTIMORE, MD 21208 RICHARD FLAX/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/14/2009 | FINKSBURG, MD BETH JACOB CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 1500 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pun **Physician** /Medical Examiner Caquentiary flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death o. 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2□No 1 Yes certificate ! 1∐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient P this 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: After t To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Л Registrar's Signature 32. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40062 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2009 Physician/ 4 . 27 AM ecember Gwynn Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SINCU HOSpitul of Raltimore Baltimore 6, Sex 1 A M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 067177941 Maryland Director 68 215-40-4154 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21216 3510 Powhatan Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ori 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic MTA 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Gwynn Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Powhatan Ave., Balto., MD 21216 Donald D. Gwynn Jr.(Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Loudon Park Cem. 4 Donation 5 Other (Specify) 12/18/09 Baltimore, MD 21. Si nat re of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Balto., MD 21217 oane Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Subcapsular liver humatema Pnysician/ disease or condition Medical resulting in death) Due to (or as a chasequence of) Examiner Lalure Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Adeno cavi inomo resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death ed by the a detached f 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes mellitus, Division of Vital Records, 1 Yes 2 No 3 Probably 4 onknown Completed cerebral vascular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed this certificate 2 3 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40063 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Paul H. Glock P^{M} 15, 4:25 December 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Quail Run Assisted Living Baltimore 8. Date of Birth (Month, Day, Year) 6, 1939 **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7 Age (In vrs last birthday) **Funeral** Months Days Hours Balt. Maryland 214-36-7696 11 M 2 □ F 70 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Evandmer rotat be notified at Baltimore Baltimore 1 ☐ Yes 2 No Director Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 9900 Walther Blvd. 21234 OF America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itel 1 Never Married 2 Married 1 ☐Yes 2 No Specify þ white 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) professor education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cola May Hudson ပု William B. Glock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther H. Reback/ friend 8810 Walther Blvd. #2014 Baltimore, Maryland 21234 Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVAILS FULLETAL Chapel 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 13, 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 45/51 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown nificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c, License number 30. Name and address of person who completed cause of 0 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

21215-0036 Silian Baltimore, Maryland Graves

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05 A M William L. Graves December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center Social Security Number Sex 1XXM 2□F If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Rhode Island Hours 8/9/1926 83 Director 037-18-7593 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits Director N/A MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3601 Clarks Lane Unit 501 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc.
White þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. WWII Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Social Security Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Zella Lovett William E. Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Somerset Bay Drive Glen Burnie MD 21061 Marjorie A. Wood / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town State Date cemetery, crematory or other place)
Hilltop Service Cor. 12/15/2009 1 Burial 2XXCremation 3 Removal from State Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Towson, MD 21204 22. Name and Address of Facility Inc. 1050 York Rd. Ruck Towson Funeral Home, 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician EUMOMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examine miTITIA TEARS Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 욘 inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Erry 0059190 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WACHMETON 31. Date filed (Month, Day, Year, 32. Registrar's 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40065 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8, 2009 6:39 P.M December Daniel Clark Grubb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DeC . 8 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 72009 Days Min. Months 1 12 1 × 1 2 □ F Maryland Director N/A Usual Residence of Decedent a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Bel Air 1 ☐ Yes 2 No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1884 Oxford Square d other than "natural", or items 23a event, It e l'exical Examiner must le 21015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 7 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be 2 should be fi and Mental F Stan Michael Grubb Diana Lynn Weese ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1884 Oxford Square Bel Air, Maryland 21015 Stan Grubb / Father Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Dec. 10, Pages 1 Evans Funeral Chapel 1 ☐ Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Forest Hill, Maryland Nir
Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
Newport Drive Forest Hill, Maryland 21050

Approximate 21. Signature of Funeral Service Licensee COLL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only document on each line. Immediate Cause (Final Physician 4nence disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entire Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tra Box 68760g Due to (or as a consequence of) Physician/Medical as IF FEMALE for use 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 🗆 No 2 4 1 □Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of License number

Registrar

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Dr. Bel Air, MD

n 23a) (Type, Print)

32. Registrary Signat

30. Name and address of person who completed cause of death (Its

31. Date filed (Month, Day, Year)

OEC 16 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death **Physician** MILDRED /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street 4b. City. Town, or Location of Death Examiner Seasons Hospice@Northwest Hospital Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😾 F 75 Yrs Director 219-38-6415 Sept.4,1934 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at X☐Yes 2☐No N/ADirector Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4026 Lewiston Ave 21215 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify SpecifyBlack ≥ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6th grade Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Contee Rosa Matthews ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Harcum/ Husband 4026 Lewiston Avenue Baltimore, MD 21215 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 12/18/09 1 → Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet. 4 Donation 5 Other (Specify) Cem. Owings Mills, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lic 5240 Reisterstown Rd Baltimore MD 21215 23a. Part 1 Enter the disea shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** /Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl Physician: The 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 9d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 208 MD Date filed (Month, Day, Year) 32. Registrar's Signature State 16 2003 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **P**hysician Month na RIY be, 1 /Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @NORTHWEST HOSPITAL RANDALI STOWN er 1 Year I If Under 24 Hrs BALTIMORE 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) State or Foreign **Funeral** Hours Min. Months Days 1 □ M 2 💢 F 216-20-8977 82 Director 11/16/1927 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 53 RIVER OAKS CIRCLE Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No ģ Specify. WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magnesia. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BALTIMORE CITY COURTHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM WASSERMAN 2 MINNIE RUBIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 RIVER OAKS CIRCLE, BALTIMORE, MD 21208
ace of Disposition (Name of Date 20c. Location - City or Town, State GERALD HANKIN/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) <u> 12/15/2009 BALTIMORE, MD</u> ZION CEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC 10000 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎢 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a... autopsy perform Yes certificate 2 🗆 No 1 🗆 Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) OSPICE Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation i Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier

State Registrar

Date filed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 40068 Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Hoffman Physician/ December 13, 2009 Margaret 7:34 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Aug 27, Year) 920 Months Hours 1 🗆 M 2 💢 F 219-14-2411 89 Mary land Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Phoenix 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral U.S.A. 14533 Manor Road 21131 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Viola Μ. Roade Humphrey Bernard Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14533 Manor Rd., Phoenix, MD 21131 Debbie Eberling-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12/16/09 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner TUR HOURSCULA Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) cate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be hementia 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 100 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Matural 5 Pending injury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 TOW SUN MM 32 Registrar's Sgnature 2003 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2009 12:15 PM James E. Medical Hines 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 9749 Denrob Court Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 🛛 M 2 🗆 F Months (Month, Day, Year) 212-30-0504 76 Director January 13 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Parkville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9749 Denrob Court 21234 U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lord Baltimore Cleaners Route Sales d other t's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ O'Conner Hines James Ida Μ. Ouinn permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9749 Denrob Court, Parkville, Maryland 21234 Mrs. Darlene M. Hines / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛛 Other (Specify) FILCTIONENT cemetery, crematory or other place)

Dulaney Valley Memorial 12-09-2009 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a ornsequence of) disease or condition concer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) and I-transit Exam The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -Oltano D40850 December 16, 2009

State

DHMH 17 Rev 7/2009

Registrar

Bultimas MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

vonne Ottaviano MD. 9103 Franklin Square Dr.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40070 Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 PM ANIC EXANG 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore VAMEDICAL CENTER ALT MORE If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) 64 yrs 8. Date of Birth Country) 9. Birthplace (State or Foreign **Funeral** 152-36-7532 Months (Month, Day, Year) 9 / 23 / 45 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County N/A and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location Baltimore 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 21217 10g. Citizen of What Country? Funeral 726 N. Fremont Ave USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian African Completed by 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 If Yes, Give 1969-75 Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: American 3 Divorced 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Laundry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alice Gardener ဂ Samuel Harper 19a. Informant's Name/Relationship (Type, Print)
Jean Bell/Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 N. Luzerne Ave, Balt., MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12/16/09 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Fulleral Service License 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PIBATION disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last **To the Hospital or Attending Physician**; The law requires that the death certificate be executed Metastatic the burial-trans attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death sate has been signed by the spage 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be Other: 2 1 No 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Yea

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32. Registra

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BAHIMORE MD 2,201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOHNE OFMBER 9 2009 OAM Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AMARITAN BALTIMORE . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-54-8126 Months Days Hours Dec. 1, 1949 Director 60 Maryland Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3520 East Northern Parkway 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. white If Yes, Give Year or Dates Completed Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Urban Hays Evelyn Camm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn C. Hohne-mother 10 Pendyrus Street-Delta, Pennsylvania Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Dec.14,2009 Parkville, Maryland Moreland Memorial Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation 8
8800 Harford Road-Parkville, Maryland 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of lingary that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After Natural
Accident
Suicide work? 5 Pending injury 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0058913 BALTIMORE, MARYLAND 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD BAHL MANISHA 31. Date filed (Month, 32. Registrar's Si

Registrar

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	and **		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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9	permit. Pages 1 an Department of Hea Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation	3 DRamoval from State	1 0	emeterv. cre.	sition (Name of matory or other pla	ce)	Date 1	20c. Lo	ocation - City or	Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland | Department of Health and Mental Hygiena | State of Maryland | Department of Health and Mental Hygiena | Properties | Properti Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** (5. John 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rehabilitation V.A. Center Baltimore N/A8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F Months Days Hours Min. Director 118-09-4907 93 Dec.03,1916 Poughkeepsie,N.Y. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the "horizal Examine round to no filled at Director 1 ☐ Yes 2 ☐ XNo Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 United States 1316 Doves Cove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ≧Yes 2 □ No If Yes, Give W•W•II Year or Dates: 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manuf. Consulting Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Manuf. Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Mortimer Hart Julia Gardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia H. Van Natten (Dau.) 1316 Doves Cove Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec.11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 □ Donation 5 □ Other (Specify) 2009 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Action Ctr. 325 York Road Timonium, Maryland 21093 2325 York Road Timonium, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dens /Medical Du lo (or as a consequence of): Examiner ALTUN APPROVED BY WEDICAL TIME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine o (or as a consequence of attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical SERTIFIC. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown law requires that the cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 ☐ Yes 2 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Attending (Montri, ca.)

| Unknown
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Natural 5 Pending investigation feel in bedroom 1 ☐ Yes 2 ZWo death. 2 Accident al or Attends after death diessi16 filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or R. al Route Number, City or Town, State) 4 Homicide 316 within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's signature 31. Date filed (Month, Day, Year) 31515 State 2009 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 14, 2009 Heiges 12:49A M Geraldine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Summerville of Westminster Westminster Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Oct 4. Months Days Hours Min. Director 204-01-7791 91 Pennsylvania Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Washington Road 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 X Widowed 4 Divorced Specify: Completed White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the 12 01 Bookkeeper Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fishe1 Mary Tritt Eckert George 1 and 2 should to f Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4309 Howard Drive, Sykesville, MD Lisa Heiges Hopps/Daughter tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 12/1^D7^t709 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21. Signature of Furferal Service Licensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. Clary 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enter the disease, or conclications that bused shock, or heart failure. List only on a cause on such line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, icate has been siç 7, page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending P 124 hours after death. Funeral Director: After the leted filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 124 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one)

0 V

State Registrar 29b. Signature and title of certifier

John W. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature erma

Middleton,

6

DHMH 17 Rev 7/2009

,688 C Poole Road, Westminster, MD

December 15, 2009

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Kenneth Harn December 14,2009 510 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Mercy Medical Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex 1X M 2□ F **Funeral** Date of Birth (Month, Day, (Month, Day, Year)
December 31.1941 Months Days Hours Min 213-36-2947 Director 67 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Pennsylvania York New Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16885 Draco Road U.S.A. 17352 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No ģ 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Chauffeur Funeral Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Kenneth Wesley Harn. Sr. Helen Voigt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna H. Harn (Wife) 16885 Draco Road New Park, Pennsylvania 17352 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Michael's Ukrainian Cem. 12/19/09 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCilly Polyniak Funeral Home, P.A. 130 East Fort Avenue Baltimore, Maryland 21230 10 llens 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Jeps 15 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 122955 December 14,2009

Registrar
DHMH 17 Rev 1/2001

State

Place

Baltimore, MD

Pasi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ismai

31. Date filed (Month, Day, Year)

OFC. 16 2009

301 Saint

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 40076

		1- For State Certificate of Death Reg. No.															
Physicia		Decedent's Name (First, Midd	le,Last)								2	. Date of De	ath	_		<ol><li>Time of Deat</li></ol>	n
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Funeral		5. Social Security Number	6. Sex	1	7. Age (In yrs.	last birtl	hday)	If Under 1	1 Year	If Under	24Hrs.	8. Date of E	Birth(MN		9. Birth	nplace (State or	
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136 hin 72 hours afte e. than "natural", edical Examiner	ᅙ	15. Decedent's Education (Spe			e completed)			s Usual Oc st of workir					16b.	Kind of Bus	siness/Ir	ndustry	
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ould d Me	2	19a. Informant's Name/Relations			(Street	and Numi	ber or Ru	ıral Route N	umber,	City or Town	n, State,	, Zip Code)					
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sheraumatic event, the Medical Examiner must be notified at once		Brenda McFad	<u>d</u> en	(Daug		7	13 C	<u>he</u> rr	у В	los	som	Way,	Bal	to.,	MD	21201	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rinjury or other traumatic event, the Medical E		diletal Service	6	1/11	1.00	1 in	ا يُرَوِّ	sepñ	H°.	Br	own	Jr. Ave.,	Fun	eral	HO	me MD 212	17
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Jamai Keyno Keates 09-09654

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Rea. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 12, 2009 0722 hrs Jamal Keon Keates Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore Rear of 2457 Shirley Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Davs Hours Months 14,1982 220-98-9042 Maryland 27 July Director 1X XM 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location uny 10a State 10h County 1 X Yes 2 No Baltimore or items 23a or 28a-f show must be notified at once. Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 2916 Roslyn Avenue 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or Nodeath with Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married 2 X No Yes Black Specify permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examing: m If Yes, Give Year 1 Yes 2 X No specify: Divorced 3 Widowed ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) þe during most of working life. DO NOT use retired) Maryland Relocator Elementary/Secondary (0-12) College (1-4 or 5+) Complet Laborer Baltimore, MD 21215-0036 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertina Womack æ Henry Thomas Keates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 Sheffield Ave Pleasantville, NJ 08232 19a. Informant's Name/Relationship (Type, Print ) Henry Thomas Keates/ Father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lansdowne, Maryland 12/19/09 Zion Cemetery Mt. Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service/Licensee 5240 Reisterstown Rd Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death Medical a. Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE Year Day 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown signed l be deta à Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? has 1 🗸 Yes ✔ Yes 2 2 No The After this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical director, Division of Vital Be Other, examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient DOA 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work' 27. Manner of Death Certification: Subject shot Dec 12, 2009 0714 hrs Yes 2 V No Natural 5 Pending Director: 2 Acciden Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Suicide Could not be or Town, State) Rear of 2457 Shirley Avenue, Baltimore, Md determined (Specify) Alley 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 12, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year, State ULU Registra ORIGINAL

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	show dat	tor		10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ralD	10e. Street and Numb 6940 BR00		)AD #2A			10f. Zip Code 21215			10g. Citizen of	f What Cou SA	ntry?
	eath w	Funeral	11. Marital Status	KMILL RO	12. Was Deceder			Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		ace - Americ	can Indian,
36	after d		1 Never Married		Armed Forces 1  Yes 2 If Yes, Give		- 1	Yes, specify Cuba	in, Mexican, Puerto  Specify:	Rican, etc.)	Bla Specif	ack, White,	
21215-0036	atural	Completed	3 ₩ Widowed 4	15. Decedent's Ed	Year or Dates			ent's Usual Occup			16b. Kind of		WHITE
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auc	be file ental F ked o ic eve	10 E	17. Father's Name (Fir	st, Middle, Last)	KRUPNIK				18. Mother's Nam UNKNOW			^{ne)} UNKNO	M./M
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Baltimore,	m O == =		20a. Method of Dispo	Cremation 3	Removal from Sta	ate C	emetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location	•	,
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P.O.	ires that the signed by do be detailed	by P	Part II. Other signification	ant conditions co	ontributing to death	n but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?
rds,	requires been sig should b	ted								1 🗆	Yes 2 No	3 🏻 Pro	bably 4 🗆 Unknown
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Ä	ician: The la certificate ha ector, page		25. Was case referred	to medical				26 PI	ace of Death (Chec	1 🗌 Yes		1 Yes	2 🗆 No
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Jo (	r Attending Phy ter death. rector: After this by the funeral o		27. Manner of Death 1 Natural	5 Pending	28a. Date of ir (Month, I	njury Da <i>y, Year)</i>	28b. Time of injury	28c. Injun work	y at	28d. Describe h			
sior	l or Attend after death Director: A	Certificate:		Investigation	e -	niury - At ho	me farm stre	M 1 L	Yes 2 □ No	28f Location (S	treet and Num	her or Pura	I Route Number,
Division of Vital Records,	0 # 5 :=		4 L Homicide	determined		etc. (Specify)				City or Tow		ber or nura	r noute ivamber,
ſ	To the Hospital or within 24 hours aft to the Funeral Dir completed filled in	Medical	29a. Certifier 1 (Check 2 conly one) 3 c	Medical Exami	sician: To the best iner: On the basis o se Practioner: To t	f examination	and/or invest	igation, in my opinio	on, death occurred a	the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.
1	vithii Comp	-	29b. Signature and titl	le of certifier		$\sim$		29c. License			29d. Date sign	ed (Month,	Day, Year)
			PIW	eja		~ >		124	4217		D & C	-13.	2009.
			30. Name and address	s of person who o		f death (Item	23a) (Type, P	e Ral	more	2 de	5 2	1215	
	Star Registra		31. Date filed (Month,	Day, Year)	32. Regis	strar's Signat	ure Asy	es.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month CEMBER Day Physician/ Koehler Jane ٧. 12:55A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Towson Baltimore Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 1945 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔀 F Marwrand 64 229-50-1386 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Bel Air Harford Md. 10g. Citizen of What Country? 10e. Street and Number Funeral USA 1202 Greystone Road 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life, DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Finance Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) ပ္ Virginia Gaynor Patrick Donald Giacomo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bel Air, Maryland 21015 1202 Greystone Road Mr. Christopher Koehler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hilltop Ssrvice Corp.:12/16/09 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of scause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ CARDIOGENIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner APICAL BALLOONING SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BLUNG CANCER 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 26. Place of Death (Check only one) To Be ( 25. Was case referred to medical examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? after death. Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The decided Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a D26002 ause of death (Item 23a) (Type, Print) s of person who completed

State Registrar 32 Registrar's Stanature

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year HOWARD KELLY DEC. 3, 2009 2:15 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5 LAKE FOREST CT PERRY HALL BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ₹ M 2 □ F 213-16-3013 89 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 □Yes 2 → No BALTIMORE PERRY HALL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 LAKE FOREST CT 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING CIVIL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLEN MCGEE WILLIAM EDWARD KELLY, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA POTTER-DAUGHTER 5 LAKE FOREST CT BALTIMORE, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND CEMETERY 12/17/09 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service License MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or shock, or heart failure. Is Immediate Cause (Find disease or condition resulting in death) prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny highty or other traumatic event, the Medical Evander costs to rettried at once.

Baltimore, Maryland 21215-0036

attending physician 0 ģ signed I

To the Hospital or Attending Physician: The law requires that the death certificate be executed Director: Vithin 24 hours and To the Funeral Dir

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions  CONGESTIVE	: // / -	sulting in the underlying	cause given in Part I.		se contribute to the cause of death?  Z No 3□ Probably 4□ Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐ D	OA Other: 4 \(\bar{\pi}\) Nursing	Home 5 Residence 6	G ☐ Other (Specify)
27. Manner of Ceath 1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day, Year) on	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	Physician: To the best of my kn aminer: On the basis of examin and manner stated.				and manner as stated. place, and due to the cause(s)
20h Signature and title of certifier	/ /	29	o License number	29d. Dat	e signed (Month. Day Year)

State Registrar

DR. JAMES EBELING 31. Date filed (Month, Day, Year)

DEC 1 6 2009

OSLER DR SUITE Registrar's Signature

em 23a) (Type, Print)

BALTIMORE. MD

09-09552	
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iditya M. Kulkar		1- For State	laryland / Depa <i>Cei</i>	artment of rtificate of		Mental H	_	200	ng Loos:
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)					2. Date of Death		3. Time of Death
Medical Exami		Aditya Mayur Kulkan					December		1955 hrs
		4a. Facility Name (if not institution, give stree Western Maryland Health Syste		4	b. City, Town, or L Cumberland	ocation of Death		4c. County of De Allegany	ath
Funeral Director		5. Social Security Number 6. Sex 1 X M 2	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	(MM/DD/YYYY) 9. For	Birthplace (State or eign Country) India
		Usual Residence of Decedent		T			1-7		10d. Inside City Limits
how any	١	10a. State 10b. County  Maryland Montgomery		Town or Location					1 Yes 2 X No
Aaryland 28a-f show Lat once.	Director	10e. Street and Number	·	Silver	10f. Zip Code		10	g. Citizen of What C	ountry?
with the Maryland ns 23a or 28a-f sho be notified at once.	ä	1015 Downs Drive			20904	+		United St	tates
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. aut: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral		Vas Decedent Ever in U Armed Forces? Yes 2 X No		Decedent of Hisp es, specify Cuban,			14. Race - An White, etc	nerican Indian, Black,
after d al", or ner m	by F.	3 Widowed 4 Divorced If Yes, or Dat	Give Year	1	Yes 2 X No	specify:		Specify: As	ian-Indian
hours a		15. Decedent's Education (Specify only high	nest grade completed)		's Usual Occupations st of working life.			16b. Kind of Busine	ss/Industry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	5+	Attorn	NOW.			Law	
5-003 iled withi Hygiene. d other th	Cou	17. Father's Name (First, Middle, Last)	J1	ACCOLL		8.Mother's Name	e (First, Middle, M		
MD 21215-0036 to 2 should be filed within 72 thin and Mental Hygiene. In 77 is marked other than "aumatic event, the Medical	Be	Mayur Kulkarni					Bhupatk		
ID 2 shoul and M 77 is m	٩	19a. Informant's Name/Relationship (Type, P Mayur Kulkarni/Fath	•					ber, City or Town, St	yland 20904
e, N l and 2 Health item 2		20a. Method of Disposition	20b.	Place of Disposi	tion (Name of cem			20c. Location - City	
Baltimore, MD 21215 permit. Pages 1 and 2 should be file Department of Health and Mental H Importaut: If item 27 is marked of injury or other traumantic event, th		1 Burial 2 X Cremation 3 Re 4 Donation 5 Other Specify:	moval from State Mor	itgomery ematorii	im, Inc.	Dec.	13. 2009	Rethesda	, Maryland
Salti ermit. epartm nports ijury o		21. Sign of re of Funeral Service Vicensee	*	Robe	ame and Address	of Facility Chrey Fune	eral Home/	Bethesda-Ch	evy Chase, Inc.
Physician	5.5	Haron II. Mauri 23a. Part I. Enter the disease, or complication	MO	1530   /55	/ Wisconsi	n Avenue,	Bethesda,	, Maryland 2	20814 Approximate Interval
/Medical		failure. List only one cause on each line	ertensive						Between Onset and Death
xaminer			(or as a consequence of		CICIOCIC	Cardio	vasculai	uiscase	
	ē	Sequentially list conditions, if any, leading to immediate	(or as a consequence of	of):		1			
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50, te be executed ysician and burial - transit	EX	events resulting in death) Last dd.	(or as a consequence of	<i>n).</i>					
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876( iificate ng phys		IF FEMALE: 23b. Was decedent pregnant in the	. If yes, outcome of preg	nancy	al death 3	Ectopic pregna		23d. Date of deli Month	very Day Year
Box 68760, s death certificate be the attending physicial for use as the buri	Physician/N	past 12 months?	Pregnant at time of de		ner (Specify)				
). Bc the dea	Phy	9	Unknown  buting to death but not i	resulting in the u	nderiving cause gi	iven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
, P.O.							1 Yes	2 No 3 1	Probably 4 🗸 Unknown
of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed by						24a. Was a		e autopsy findings available to completion of cause of
Recc The lav	E O	,					perfor		h? Yes 2 No
ital Rec ician: The l s certificate l	Be	25. Was case referred to medical examiner?				of Death (Check			
1 of Vi ling Physi After this funeral dir	유	1 Yes 2 No	i inpatient 2	ER/Outpatient 28b. Time of Ir		Other Mursi	ng Home 5	Residence 6 0	Other:
OD C ending ath. or: Aft	tion	1 X Natural 5 Pending	Ba. Date of Injury (Month, Day,Year)			es 2 No			
Division pital or Attendiours after death. eral Director: Affilled in by the fu	Certification:	Suicide Could not be	8e. Place of Injury - At h	nome, farm, stree	et, factory, office bu	uilding, etc.	28f. Location (S or Town, S		r Rural Route Number, City
the Hos hin 24 h the Fun upletely	Medical Co	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner:On the	e basis of examination a	dge, death occur and/or investigat	red at the time, da ion, in my opinion,	te and place, and death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due t	stated.
To with	Me	29b. Signature and title of certifier	nanner stated.		29c. License	number		29d. Date signed	(Month, Day, Year)
		Hansell Buther 11. M	(J)		O.C.N	M.E.		December 9,	2009
16)		30. Name and address of person who complete Pamela E. Southall, MD Ass	eted cause of death (Iter		1 Penn Street	, Baltimore,	MD 21201		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat						
Regist		<u>ыеС 1 6 2009</u>	kura A.	parks			-		
DHMH 17 Rev 1/2	001			ORIGINA	L				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BLEMBER Melvin 2009 P. Klemkowski 6.30 PM 11 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death ANNE AUT, MORE WASHINGTON MRIDICAL CE (HEU EUN DE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Numbe XXM 2 F Months 219-28-7479 82 4/12/27 MD Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City. Town or Location MD N/A Baltimore City 1KNes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1240 Hull Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No White If Yes, Give Year or Dates: Specify: WWII 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Klemkowski Frances Bilenska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Mark Klemkowski / Son 1420 Richardson Street, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/2009 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Victor P. Doda, Jr2. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATRIAL FIBRUATION disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury SMGECTIVE that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 1 ∐ Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

Director

Funeral

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Completed

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death

72 hours after

1 and 2 should be filed within 7 Health and Mental Hygiene. em 27 is marked other than "

Pages 1

Maryland 21215-0036

Baltimore,

EM KON

I

Physician/Medical Examiner

attending physician and for use as the burial-tran been signed by the should be detached certificate has treetor, page 2 s funeral director.

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Completed

Be

Certification: To

Medical

After this

after death

within 24 hours a

filled in by

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Part II. Other significant cond

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ne and address of person o completed cause of death (Item 23a) (Type, Print)

6 ZUUS

JABATO

31. Date filed (Month, Day, Year)

(Check only one)

29c. License number 45149 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

tocoiral SUNVE 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09645 State of Maryland / Department of Health and Mental Hygiene Jeffrey Wayne Keith 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Deat Physician/ Month Day December 11, 2009 1620 hrs Medical Examiner Jeffrey Wayne Keith
4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Garrett 13000 Block of Maryland Highway Swanton If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) Months March 6, 1964 Director 45 236-19-6480 1 XXM Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 XX No Swiss W١ Nicholas hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26690 USA P.O. Box 181 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 2 Married Never Married Yes  $^{2}XX$ White 4 XXDivorced If Yes, Give Year Yes 2 XX No specify: Specify: 'natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Firen of Health and Mental Hygiene.
nnt: If item 27 is marked other than " the Medical Baltimore, MD 21215-0036 Hanigan Reclaimation Equipment Operator 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be or other traumatic event, Norma Lou Backus Keith James Clark Keith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 26690 P.O. Box 181 Swiss, WV Norma Lou Keith Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition hrematory or other place) 1 XXBurial 2 Cremation 3 XX Removal from State partment o Sigms Memorial Church Cem | Dec 16, 2009 Swiss, WV Donation 5 Other Spe ture of Funeral Se 22. Name and Address of Facility Fink Funeral Home. P.A. uecor 426 Crain Hwy S., Glen Burnie, MD 21061 MO1148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** is ea: Between Onset and lure. List n each line Death Medical Multiple Injuries Cause (Final disea Examiner or condition sulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death 5 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown þ ۵. Completed Records, 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of performed' death? page 2 ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Hospital:, Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 this 1 V Yes ဥ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 27. Manner of Death After Certification: Passenger auto auto collision FOUND: Natural Yes 2 🗸 No Pending in by the 1615 hrs Dec 11, 2009 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 13000 block Maryland Hwy , Swanton, Md 3 Could not be Suicide determined (Specify) Major Road / Highway Homicide

To the Hospital or Attending Physician: Division of Vital Funeral Director:

29a. Certifier (Check only one) 2

31. Date filed (Month

29b. Şignature and title of certifier

Margarita Korell MD.

Medical

State Registra

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Registrar's Signa

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 12, 2009

			For State Registrar	State of Maryland	•	rtment o			Mental Hy	giene Reg. No	2009	400	185
	Physicia /Medic	al	Decedent's Name (First, Middle, Last)     R  4a. Facility Name (If not institution, give str	obert H. Love	less	4h City Toy	wn or loc	ation of Death	2. Date of De Month Decembe	er 12	Year 2009	3. Time of 3:50	Death A ^M
1	Examin Funeral Director		Montgomery Hospice  5. Social Security Number 6. Sex		t birthday) . Yrs.	Ro If Under 1	ckvi]			ı	lontgome	olace (State o	
	ъ	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomer  10e. Street and Number  7010 Pyle Road		Town or Loc	cation thesda		17		10g. Citiz		-	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exeminar must be redified at	ed by Funeral	<u> </u>	. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II	. 1	□Yes 21 <u>8</u> lent's Usual 0	it of Hispa Cuban, M No Si	nic Origin? (S lexican, Puert pecify:	pecify Yes or No o Rican, etc.)	1	4. Race - Ameri- Black, White, Specify: White	hite, etc. White	
12 0	2 should be filed within 72 rand Mental Hygiene. Is marked other than "naf aumatic event, the Moder"	Be Completed by	(Specify only highest grade of Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)			ne (First, Middle	, Maiden S	onstruction					
, Maryland	and 2 should beath and Ment salth and Ment 27 is marked er traumatic e	101	Harry Roland Love  19a. Informant's Name/Relationship (Type Margaret M. Loveles	n Cather _{ural Route Numb} sda, Mar	er, City or ylano	Town, State, Zij 1 20817							
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition  1 Burial 2 Cremation 3 Read Donation 5 Other (Specify)  21. Signature of Funeral Sovice Licensee	f English	ember 14, 20c. Location - City or Town, State 2009 Bethesda, Maryland by Funeral Home/ Chase, Inc., Bethesda, Maryland 20814-								
	Physician /Medical Examiner		23a. Part 1. Briter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. cause on each line.  End Stage  Due to (or as a conseque	Do not ent Alzhe	er the mode	of dying, s	uch as cardia	c or respiratory a	arrest,		Approximate Interval Bet Onset and I	e ween
60,	be executed ician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque									
O. Box 68	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnand  1  Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	leath 3 [	Ectopic pre Other (spec				2	23d. Date of deliv Month		Year
Records, P.	w requires that the de been signed by the should be detached	₽ S	Part II. Other significant conditions control Chronic Renal Fail		ing in the u	nderlying cau	se given in	n Part I.		Yes 2[	se contribute to  No 3 Pro  24b. Were aut	bably 4	Unknown
	Physician: The law or this certificate has b aral director, page 2 sl	Be Completed	25. Was case referred to medical examiner?	ospital:			1 0.1		auto perfi 1 □ Yes ath <i>(Check only</i>	ormed? 2 No one)	prior to c death? 1 □ Yes	ompletion of c	ause of
_	Attending Phy death. ctor: After this y the funeral d	Certification: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide  1 ☐ No.   The content of the content o	2 □ Inpatient 2 □ E  28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hombuilding, etc. (Specify)	f 280	c. Injury at Work? 1 ☐ Yes		Home 5 ☐ Res 28d. Describe 28f. Location City or To	how injur	y occurred d Number or Ru			
1	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical C	(Check only 2 Medical Examination)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, deat on and/or in	vestigation, i	n my opini License nu	ion, death occurrence	ce, and due to the curred at the time	, date and 29d. Dat	d place, and due te signed (Month	to the cause(s	
	F 3 F 8		30. Name and address of person who com	npleted cause of death (Item		Print)		748	1		ecember		)09
	Sta	ate	Jocelyne Kouatchou, 31. Date filed (Month, Day, Year)	M.D. 6001 M		ter Mi	LL R	oad, Ro	ockville	, Ma	ryland 2	20855	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM# 26 per PHYS, G898, 12 F16/16 AND COPIES ARE Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 40086 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 10, Physician/ MOODY-GUTHRIE 6 20PM Medical 4a. Facility Name (if not institution, give street and number) Emerald Estates Examiner 4b. City, Town, or Location of Death 4c. County of Death Greenspring Avenue Baltmone NI If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 91 1 □ M 2 ▼F 216.10.962 Min **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral tunue Greenspring 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. National Institute
of Health Elementary/Seconday (0-12) 12H/ grade College (1-4 or 5+) Chemical Analyst is marked other Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ William Lola Mack Curry George 19a. Informarit's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Maisha Scott Great Grandaughter 43618 Merchant Mill Ferrace Leesburg, VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State Baltmore, MD 12/18/19 Arbutus Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaugn C. Greene Purjeval Services 8728 Liberty Road Randallstown, MD 21133 21. Signature of Funeral Service Licensee laugh C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc 🛹 cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANL METASTATIC MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS , DEMENTIA 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1PERTENSON the Hospital or Attending Physician; The law 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 5 K Residence 6 Cher (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number rectioner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Madel D0054653 12-11-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2360 W JOPPA-SUITE 210; LUTHERVILLE, MED 21093 R Dahlman, MD; 31. Date filed Month, Day, Year) 32. Registrar's #gnatur State 16 2009 Registrar

DHMH 17 Rev 7/2009

Baltimore,

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #23, 27, & 28a-1, perME, G901 3726/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ronnie M. Malone DEC 9:05 AM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNIES BALTIMORE HOS PITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 08 05 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 214.56.4816 MD Yrs **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Evan, the factor of the second of the MD Baltimore 1 Xes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 N. Calvert Street Suite 542 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Black ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, I sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Norman Malone Annie Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Heather Malone / Daughter 4295 Mary Ridge Drive Randallstown, MD 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemeter, 12/15/09 Pikesvillo, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nime and Address of Facility Vough C. Greene Funeral Services 21. Signature of Funeral Service Licensee Vaugen C. St 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PMEUMOMEA monthy /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY THE DICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ×,09289 sician and burial-trans law requires that the death certificate be execut Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: P.O. Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant MALONE 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No icate has been signed by the ; page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown VENIT DEPENDENCE Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐XYes <del>2</del>₺ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28b. Time of Injury 28d Describe how injury occurred subject pedestrian struck by a car 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 5 Pending investigation nours after death.

neral Director: Af
y filled in by the fur 2 Accident 1 ☐ Yes 2X No Aug. 2006 unk 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

roadway 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 9, 2009 24062 KHATIR ALINAFAA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avana 900 Caton Baltimore 21229 31. Date filed (Month, Day, Year)

OEC 16 2009 32. Registrar's Signature State

Registrar

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PON

		_	1- State of Maryland / Der State Amend Items 8,26 per fh/phy.,88	partment of Health and N 98 12/16/094hb	Reg. 1	N2009 40088					
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Gloria Jean Montgomery		2. Date of Death Month 12/13/20	Pay Year 3. Time of Death 2:44p M					
	Examin		4a. Facility Name (If not institution, give street and number) 236 W. Meadow Road	4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel					
Ī	Funeral Director		5. Social Security Number 216-68-9170 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Bin <b>03/</b>	24/1956 9. Birthplace (State or Foreign Country) MD					
	/aryland Ba-f show tified at	ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I Baltimor			10d. Inside City Limits 1 ☐ Yes 2 🛣 No					
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 237 W. Meadow Road	10f. Zip Code 21225	10g. <b>U</b> S	Citizen of What Country? SA					
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ام	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. White					
1215-	within 72 ho giene. <b>er than "nat</b> <b>the Medics</b>	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Emaker	ing	. Kind of Business Industry  elf-employed					
and 2	be filed w ental Hygi rked other ic event, t	l as l	17. Father's Name (First, Middle, Last) Bernard Ellis Hirsch	18. Mother's Nam Betty L.	18. Mother's Name (First, Middle, Maiden Surname) Betty L. Fisher						
Mary	d 2 should alth and M 1 27 is man		19a. Informant's Name/Relationship (Type, Print)  Betty Jean Montgomery  237	iling Address (Street and Number or Rura W. Edgevale Road,	or Rural Route Number, City or Town, State, Zip Code) ad, Baltimore, MD 21225						
Baltimore, Maryland 21215-0036	Page 1 and nent of Herant: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Date 20c. 5/2009 Ode	Location - City or Town, State					
Balti	permit. Departr Import: any inji		21. Signature of Funoral Service Licensee M01452	22. Name and Address of Facility Bailey Funeral Home 1023 Annapolis Road	and Crema , Halethor	ation Service, PA					
	Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, scaling to minimize the models cause. Enter Underlying	1 /	or respiratory arrest,	Approximate Interval Between Onset and Death					
0	ath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):								
	Hospital or Attending Physician: The law requires that the death certificate 44 hours after death.  Funeral Director: After this certificate has been signed by the attending phy sted filled in by the funeral director, page 2 should be detached for use as the	≥		Ectopic pregnancy     Other (specify)		23d. Date of delivery Month Day Year					
s, P.O	ires that the des signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death?					
Division of Vital Records, P.O. Box	The law require tte has been si bage 2 should b	Completed			24a. Was an autopsy performed						
Vital	ysician: 7	To Be (	25. Was case referred to medical examiner?  1  Yes 2 No 1  Inpatient 2  ER/Outpat	26. Place of Death (Checient 3 □ DOA Other: 4 □ Nursing Ho							
on of	ending Ph aath. or: After th he funeral	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time injury	of 28c. Injury at	28d. Describe how in						
Divisi	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate h completed filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Sta	<u> </u>					
	the Hosp in 24 hot the Fune upleted fi	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or inv 3 Certifying Nurse Practioner: To the best of my knowledge.	estigation, in my opinion, death occurred a e, death occurred at the time, date and pla	t the time, date and pla	ace, and due to the cause(s) and manner stated.					
	P with Co.		29b. Signature and title of certifier	29c. License number  DISF76	29d.	Date signed (Month, Day, Year)					
_			30. Name and address of person who completed cause of death (Item 23a) (Type like to the complete of the compl	Smith Ar	Euro	21209					
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's signature and Street								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40089 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2019 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death ounty of Death 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9 Months Hours Min Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code Citizen of What Country? 12 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 ☐ Never Married 2 M Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 GLENDAIS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory 1 W Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No sate has been signed by the atte page 2 should be detached for a Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To I 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) WSPUL 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Natural 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day

Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40090 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 15:55 asandra 2009 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Vrs July 4,1963 MD **Director** 213-72-7153 46 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ¥ Yes 2 □ No Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified MD N/A Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2834 E. Federal St. 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs Staff Nutrition John HopkinsHosp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Gilbert Myers Mildred Todd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 5 Shenika Hilliard/Daughter Clementine Ct. Apt. 2D Rosedale, MD21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenmountCrematoryDec.21,2009Balto. Md ure of Euneral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 F PRESTON ST BALTO MD shock or heart failure. List only one cause on each line. any Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Embolism **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner carcinome Non small cell lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0 the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Records, page 2 should be 2 No 3 Probably 4 Unknown 1X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 1 ☐ Yes 2 ☐ No 2X No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ρ this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: 5 Pending investigation Division the Hospital or Attending (Month, Day Year) Injury 1 Natural 1 Tyes 2 No death. 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in account. Funeral 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ) Cum RES DOD

State Registrar

DHMH 17 Rev 1/200

32. Registrar's Signature

Tamashiro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cecilia Yshii -

31. Date filed (Month, Day, Year)

ORIGINAL

December

600 North Wolfe St, Baltimore, MD, 21287

09-09650									
James	Moore								

mes Moore	1-	For State	State of Mary	land / Depa <i>Cei</i>	artment o rtificate o	f Health <i>f Death</i>	and	Menta	l Hygiene	Reg. N	. 200	9 40091
Physician		gistrar Decedent's Name (First, Mi	ddle,Last)						2. Date of Month	Death	v Vear	3. Time of Death
ledical Examine		Jame	es S	•	M	oore			Decem	ber 11	1, 2009	2125 hrs
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	Ļ	Union Memorial Hos		7. Age (In yrs. I	last hirthday)	If Under		If Under 2	4Hrs 8 Date o	f Birth(N	MM/DD/YYYY) 9. B	irthplace (State or
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5-0036 led within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f she the National Examiner must be notified at once the National Anni Enterior of the forester or the National Anni Enterior of the forester or the National Anni Enterior or the National Anni Enteri	1	1. Marital Status		Decedent Ever in U I Forces?	J.S. 13. W	/as Deceden Yes, specify	t of Hisp Cuban,	anic Origin Mexican, P	? (Specify Yes ouerto Rican, etc.	or <b>N</b> o- )	14, Race - Ame White, etc.	erican Indian, Black,
or ite		Never Married 2	1 Yes	s 2 X No	1	Yes 2					Specify:	Black
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21215-0036 ould be filed within 7 Mental Hygiene. s marked other than it event, the Medica	å L	John	L.	Moore	Lion sent	Address	/Chrant	Sal	lie	Numbe	Alexand er, City or Town, Sta	er ate Zip Code)
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, MD and 2 sho salth and em 27 is raumati		Felice Moo:	re/Wife	20b.	. Place of Disp	osition (Nam			Date	1 2	20c. Location - City	or Town, State
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Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumation		al i	W 3	Je	386	£4121	E.B	PRES	RUGG§T	FUN	ERAL HO	ME ₂₁₂₁₃
Physician	4	23a. Part 1. Enter the disease failure. List only one ca	e, or complications the	at caused the deat	th. Do not ente	r the mode o	f dying,	such as car	rdiac or respirato	ry arrest	t, shock, or heart	Approximate Interval Between Onset and
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	-	1 Colin	Po 10	)			O.C.	M.E.			December 15	, 2009
	}	30. Name and address of p	erson who completed	cause of death (I	tem 23a)							
		Laron Locke MD.	Assistant Me	dical Examine	er 111 Pe	enn Stree	t, Balti	more, M	ID 21201			
	ate	31. Date filed (Month, Day,	Yearing A3	32. Registrar's Sign	nature fact	dol						
Regist	rar	DEC 16	PARA COL	A. M.	9 /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Garv Steven Mackey Medical 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death National Institutes of Health Bethesda, MD Montgomery 6. Sex 1 ፟፟፟፝ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. April 22, Year) 963 Hours Massachusetts 011-56-7053 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MA Hampden Southwick 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Laurel Ridge Road 01077 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ⚠ No 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) Director Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Mackey permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic s Sandra Lavallev 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Laurel Ridge Road, Southwick, MA 01077 Kristen Mackey/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 17. St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Westfield, MA 21. Signature of Funeral Service License Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Willia M01173 Kin 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final wet and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) GRAPT-VERSUS-140ST Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical HOCYTIC LEDKEMIA Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown Division of Vital Records, P.O. þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an cate has t ; page 2 s autopsy derformed? Yes 2 \(\sigma\) No certificate : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b, Signature and title of ce 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of per

MICHAEL F

BISHOP

6 2003

DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

32. Registrar's Signature

on who completed cause

980

10 Center Drive, Bethesda, MD

2000

20892

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:26 PM Arlene May Marcinko BECEMBER 2009 /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HENES BATILIAS OSPITAZ Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🖺 F Months Days Hours 215-38-5983 68 1941 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evan it with using borrotified at 10a. State Director 1 ☐ Yes 2 1 No Derwood Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7845 Briardale Terrace 20855 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: Specify: White Completed by 3 ₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care 12 Day Care Provider 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) ပ William Dumbroski Louise Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara M. Custer/Daughter 24505 Fossen Road, Damascus, Maryland 20872 Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 14. Pages 1 Department of Important: If it any injury or o 1 

Burial 2 □ Cremation 3 □ Removal from State 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bert A. Pumphrey Funeral Home/Rockville, Inc. MO1548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATOR Immediate Cause (Final **Physician** 4 BA45 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** new mon Sequentially list conditions, Physician/Medical Examiner is any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tra Due to (or as a consequence of) 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Ho ρ Month Year 5 ☐ Other (specify) o 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but per resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ucmorran 1 | Yes 2 | No 3 | Probably 4 | Unknown SEPTECEWIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 2 No Vital 1 ☐ Yes 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 21H0 Medical Certification: To of After this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 80060105 hene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WAIR ( ) NICT - ICTURES MIS 700 5 COTON WELL FAMILIANTE 21225 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	aryland		rtment of				giene Reg. No	2003	400	94
			Decedent's Name (First, Middle, Language)	ast)						2. Date of De	ath		3. Time of D	eath
	Physicia /Medic		Maria Esther Mol	ina						Month Decemb	er 9		15:35	M
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town	, or Locat	ion of Death			. County of Deat		
and it	0		Holy Cross Hosp	ital			Silve					ntgomer		
	Funeral			Sex 7. Age 1 ☐ M 2 🛣 F		st birthday)	If Under 1 Year Months Day		ider 24 Hrs. Irs Min.	8. Date of Bir (Month, Da June 3	th <i>y, Y</i> ea <i>r)</i>	9. Birt	hplace (State or untry)	
	Director		214-94-0335	TO IVI ZEST	91	Yrs.				June 3	, 19	18  E1 S	Saĺvador	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside City	Limits
	Maryl f sho	힏	Maryland Montgon	ory	Rock	ville							1 □ Yes 2	No
	the l	Director	10e. Street and Number	lery	NOCK	ratife	10f. Zip Code	е			10g. Ci	tizen of What Co	untry?	
	3a or		4618 Wissahican	Avenue			2085	3			Uni	ted Sta	tas	
	ms 2	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S	3. 13. V	Vas Decedent of Yes, specify C		Origin? (Spe	ecify Yes or No		14. Race - Ame	rican Indian,	
21215-0036	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Medical Examination.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ☒ N If Yes, Give Year or Dates:	No		Yes, specify C			radoria		Black, White	e, etc. hite	
9	2 hou		15. Decedent's E	Education		16a. Deced	ent's Usual Oc	cupation			16b. k	(ind of Business/	Industry	
215	nin 72 e. in "ni	Completed	(Specify only highest g.	rade completed) College (1-4or 5	i+)	(Give life. L	kind of work doi DO NOT use ret	ne during . ired)	most of worki	ng				
21;	d with	mo.	7		, , ,	Homema	aker				Ow	n Home		
nd	al Hy l othe	Be (	17. Father's Name (First, Middle, Las	t)				18. N	lother's Name	(First, Middle	, Maidei	n Surname)		
<u>a</u>	uld b Ment arked	၉	David Villa Cort	:a				Ter	esa Mo	lina				
Maryland	sho and l is ma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Stre	et and No	umber or Rura	al Route Numb	er, City	or Town, State, 2	Zip Code)	
Σ,	and and and n 27	8	Romeo Molina/Son	ı		1							land 208	53
ore	Jes 1 For H Fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	☐Bernoval from State	20b. Pla	ace of Dispo emetery, cren	sition (Name of natory or other p	olace)	Decen	ber 15,	20c. L	ocation - City or	Town, State	
Ë	Pag ment tant; jury o		4 □ Donation 5 □ Other (Spec		Parl		Memorial I		2009				Marylan	.d
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Lice	00 -	M0154		Name and Ad bert A. Pi O West Mor	dress of F Imphre ntgome	y Funera ry Aveni	1 Home/Reie, Rockv	ockvi i11e	lle, Inc. Maryland	20850	
			23a. Part T. Enter the disease, or cor	nplications that caused	the death	7			-			-	Approximate Interval Between	een
	Physician	i a	shock, or heart failure. List only immediate Cause (Final	y one cause on each in		Foilu							Onset and De	
	/Medical		disease or condition resulting in death)	Due to (or as			. C						Days	
	Examiner			Pneumon	ia								Davs	
J		je l	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as		ence of):								
W	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
60	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	cate b	dical		d										
39	ertific ling p e as t	Mec	IF FEMALE:		7				1000		- 1			
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal	death 3	Ectopic pregna					23d. Date of de Month	livery Day Ye	ar
0.	at the dea by the a tached fo	sici	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify	)					,	
P.O.	d by	Ph.	Part II. Other significant conditions	contributing to death h	ut not resu	Iting in the ur	derlying cause	given in F	Part I	23e. Did	tohacco	use contribute to	the cause of de	ath?
Ś	ires tha signed be det	by	Hypertension	contributing to death b	at not resu	iting in the di	idenying cadse	giveiriii	arr i.				robably 4√2 Ur	
Ö	w requir been s should	Completed	пурет сеньтон											
Sec Sec	e 2 s	ldn								24a. Was		24b. Were a prior to death?	utopsy findings av completion of car	vailable use of
<u>~</u>	: The	ပိ								1 ☐ Yes			2 □ No	
Vit.	ician certif	Be	25. Was case referred to medical examiner?	Hospital:				O4h		h (Check only				
of	Physician: The la r this certificate hav ral director, page 2	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 K Inpatie		ER/Outpatier 28b. Time of	I S DON			me 5 Res 28d, Describe		6 ☐ Other (Spe	ecify)	
n n	ding Phy h. After thi funeral (	jo	1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y, Year)	Injury	V	njury at Vork? I □Yes		280. Describe	riow iriji	iry occurred		
<u>:S</u>	ttend death stor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	to a	ury - At bor	me farm etr			2 🗆 140	28f Location	Street	and Number or B	ural Route Numb	ıer
Division of Vital Records,	I or Attendi after death. Director: A d in by the fu	Certification	4 ☐ Homicide determine	d 28e. Place of Inju- building, etc	c. (Specify	) (ami, su	set, lactory, onle			City or To	wn, Sta	e)	urar rioute rionio	,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the best aminer: On the basis o										
1	the hin 24 the F	Medical	one)	and manner sta										<u>-</u>
_	Voir Con	Σ	29b. Signature and title of certifier	W -				ense num	per			ate signed (Mon		
			- Chris	NUI			D32:	332			Dec	ember 1	0, 2009	
			30. Name and address of person who											
			Suresh K. Gupta 31. Date filed (Month, Day, Year)	22 Pogistr	ar's Signat	TURO		, Sui	te 2-2	0, Sil	ver	Spring,	MD 2090	2
	Sta Registr		Jake liled (World), Day, Tear)	09 Letus	ar o oigilat	L	No. to							
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieng 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary В. Marshall 12/13/2009 12:41pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4002 4th Street Brooklyn If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 X Months 220-09-6317 90 5/15/1919 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD N/A Baltimore 1XXes 2□No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural" or items 23a or any Injury or other traumatic event. the Medical Economics. 1429 Richardson Street 21230 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ↑ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2₩☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James T. Boldowsky Anna Bander ပ 19a. Informant's Name/Relationship (Type. Print)
Linda M. Wilson / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Maude Avenue, Baltimore MD 21225 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Holy Trinity Cemetery 12/16/2009 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Victor P. Doda 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No hed by the a 9 Unknown 9 Unknown signed to contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has Diseas certificate 1 ☐ Yes 1 ☐ Yes 2 🛣 No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Grandaughter Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 ☐ Yes 2**XX**00 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA House 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death

Director: A

d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory The filled in br 4 Homicide **Eqrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) 4000 Annapolis Rd valleci mo 10 Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 7.8 per inf g899 1-6-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARTIN DELOIS 12:52 PM JACQUELINE DECEMBER 12 2009 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN 8. Date of Birth (Month, Day, Year) 1941 9. Birthplace (State or Foreign April 15, 1947 AL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 125–32–4684 **Funeral** 1 □ M 2 🕱 F Months Days Hours 68 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be refilled at MD Baltimore Owings Mills **Funeral Director** 1 TYes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5004 Willow Branch Way 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2XXIIo Specify: <u></u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Biology Professor State University 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Bryant Ester Moses Taylor ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29203 Jeffrey Martin / Son 123 Meadow Lake Drive, Columbia, South Carolina Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from State Ebenezer Cemetery 12/18/2009 Northport, 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed UNKNOWN HYPERLIPIDEMIA burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed page 2 should DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No certificate 2 X No 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ö 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ind manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0060293 DECEMBER 12, 2009 WP 30. Name and address person who compeled cause of death (Item 23a) (Type, Print) 5401 OLD COURT RD, RANDALLSTOWN MD 21133 AHMED, M.D. MURTUZA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vea 04:46 M **Physician** 12 RKE Z000 atherine 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER UNIV OF MARYLAND MEDICAL PALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XXF Months Director OCT 19, 1921 88 174.32.7029 Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Evanitrat must be regified at 1 ☐ Yes 2 ▼No Director BROOMALL/MARPLE TWP PA DELAWARE 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 233 TALBOT DRV. 19008 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼NO Specify: Specify: WHITE 2 3√X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 2 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic ပ KATHRYN ROONEY JAMES NEARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun DAUGHTER 3413 WEST COLLEGE ST., BROKEN ARROW, OK 74012 MARCARET MINK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3XXRemoval from State 5 ☐ Other (Specify) 4 Donation SS DEC. 9, 2009 SPRINGFIELD. PA PETER & PAUL CEM. 21. Sign Funeral Sec 22 Tame and Address of Facility FINK FUNERAL HOME, P.A. t/a KISH FUNERAL HOME ORY FINK M01148 1998 SPROUL RD., BROOMALL, PA 19008 cort plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final thmia 15 minute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner alvulor hooe Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: asn yes, outcome of pregnancy
□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) NAWQO 22.5. GREENE AMONE 60 State Registrar

09-09478 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 40098 Michael Wayne Mehsling, 2nd State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3. Time of Death Month Month Day December 5, 2009 1740 hrs Medical Examiner MICHAEL WAYNE MEHSLING, 2ND 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3620 Commerce Drive Lansdowne **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Director Country) 1 XXM 2 1981 MD 28 OCT. 4, 215.98.1320 Usual Residence of Decedent any 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Yes 2XX No 28a-f show ANNE ARUNDEL GLEN BURNIE items 23a or 28a-f shoust be notified at once. Director death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 209 JUNIPER DR 21060 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' 1 XXNever Married 2 2 XX No 5 Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner in WHITE Widowed Yes, Give Year Specify Δ Divorced Yes 2xx No specify: ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **SALES** FLOORING 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY JEAN BOHANAN MICHAEL W. MEHSLING, 1ST ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 JUNIPER DR., GLEN BURNIE, MD 21060 **FATHER** MICHAEL W. MEHSLING, 1ST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 χχBurial 2 Cremation 3 Removal from State DEC.11,2009 NEW CATHEDRAL CEMETERY BALTIMORE, MD Qonation 5 Other S 22. Name and Address of Facility 2 Financia Fyrend Se Lice FINK FUNERAL HOME, P.A. GRESORY FINK M01148 GLEN BURNLE 426 CRAIN_HWY. S. MD Part I. Enter the disease of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and each line /Medical Death a. Contact Gunshot Wound to Head Cause (Final disease xaminer or condition usulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - trar sician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, After this certificate has been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifu 26. Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self FOUND: Natural Yes 2 V No d in by the f 5 Pending Dec 5, 2009 1732 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide filled in I 6 Could not be or Town, State) 3620 Commerce Drive, Lansdowne, MD determined (Specify) Vehicle Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

State Registrar

OCMF 2006

29b. Signature and title of certifier

Jack Titus MD.

31. Date filed (Month, Day, Year) 009

30. Name and advess of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

2. Registrar's Signature

meny

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 6, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December To. 2009 5:31  $A^{M}$ Hugh Garland Nea1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 X M 2 □ Months Hours Min February 23, 1932 77 578-40-8093 Director Virginia Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Rockville Montgomery 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 702 Crabb Avenue 20850 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I.1. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No 1952-Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 1956 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 9 Fencing Contractor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Jesse Bog1e Neal Nannie Haze1 Harmon and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Neal / Wife 702 Crabb Avenue, Rockville, Maryland 20850 or other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December permit. Page 1
Department of I
Important: If it
any injury or or 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery Frederick, Maryland 4 Donation 5 Other (Specify) 15, 2009 21. Sign e f Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 anderest 20850-2805 23a. Pat.1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

Intracranial Hemorrhage

Due to (or as a consequence of): Approximate Interval Between 36 Hours Physician/ Medical Due to (or as a consequence of): Examiner Thrombotic Stroke 2 Weeks Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Atrial Fibrillation 2 Weeks Cause (Disease or linjury and -trar that initiated events resulting in death) Last Due to (or as a consequence of) physician al Physician/Medical Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown has been signed by the age 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mild Dementia, Mild Urinary Tract Infection 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed page icate 1 ☐ Yes 2 ☐ No certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 💢 No 1 Tyes ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 🛚 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) the Hospital within 24 hours Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Fun (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 16 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b, Signature and title of certifier

Shama

Sharma Mittal, M.D.

D0061382

14816 Physicians Lane, #152, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

December 10, 2009

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Thelma M. Nuttall December **11**, 2009 7:00 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10320 Greentop Road Cockeysville Baltimore County 8. Date of Birth (Month, Day, Year) 5. Social Security Number 232-42-7791 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 Ø F 95 Yrs. 6, 1914 Director Sept. Virginia Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Maryland Baltimore Cockeysville Director 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 10320 Greentop Road 21030 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2€ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bendix Secretary. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elijah Samuel Meadows Trixie Gutridge ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is ι Mr. Samuel E. Nuttall/ 10320 Greentop Road Cockeysville, Maryland 21030 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 15, 2009 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22 Name and Address of Facility Peacerul Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Fundral Service Licenses 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARGIA disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 🗹 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tause of death (Item 23a) (Type, Print) 30. Name and address of person who 32. Registrar's State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records.

09-09596					
John	Pruitt				

ohn Pruitt		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No. 2009 4010						1.010					
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		Certii	ilcale of L	Jeani			2.1	Reg Date of Death			me of Death
ledical Exami			Pruitt			Month Day Year December 10, 2009 0349 hrs							
		4a. Facility Name (if not institution, give:	street and number)		4b. City, Town, or Location of Death 4c. County of Death								
Fundant		5. Social Security Number 6. Sex	7 Ans	e (in yrs. last		Baltimor		If Under 2	24Hrs 8	Date of Birth	(MM/DD/YYYY)	Rirthplac	e (State or
Funeral Director		212 00 0226	vi 2F	43	Yrs.	Months	_	Hours		Dec.29		oreign Country)	
,		Usual Residence of Decedent		40. 00. 7								1404	In aird - Citive Limpite
nd how any ce.	L	10a. State 10b. County		10c. City, To	own or Location Bal	timor	e						Inside City Limits Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 5610 Fair Oaks A	venue			10f. Zip Co	de 212	14		10	g. Citizen of What USA	Country?	
ath with the terms 23a st be noti	eral	11. Marital Status  1 Never Married 2 X Married	Married Armed Forces?			as Decedent of Hispanic Ongin? ( Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - A White, e		ndian, Black,
after de: al", or i	1 Never Married 2 X Married 1 X Yes 2 No 1 Yes 1 Yes 2 No 1 Yes 1 Yes 2 No 1					Yes 2 X No specify: Specify: White							
hours 'natur		15. Decedent's Education (Specify only	highest grade com	r te	6a. Decedent's during mos						16b. Kind of Busin	ess/Industi	ry
15. Decedents Education (specify only highest grade c minute)  16. Decedent sequence of the plant of the plan						Lab	ore	r			Constr	uctio	n
Baltimore, MD 21215-0036 permit. Pages I and 3 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Danny Pruitt					e (First, Middle, Maiden Surname) on Robbins						
MD 21 d 2 should th and Me n 27 is man numatic ev	T ₀	19a. Informant's Name/Relationship (Type Susan Elaine Prui	be, Print) tt / Wife	e	_	,					ber, City or Town,		,
ore, Nest I and Street		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from Sta	to cre	nce of Dispositi matory or othe	r place)		· 1		ate	20c. Location - C	•	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specific		Fina	al Jour	-				2/2009		•	)
Ba perm Depa Impe injur		21. Signature of Funeral Service Lice	horota	Marsha	311 22. IVa	Mary PO B	lan ox	d Či 1413	rema	tion	Service	s 212	203
Physician /Medical		23a. Part I. Enter the disease, or complications. List only one cause on each	h line.									Ap _l Be	etween Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): Intoxication											
	ē	Sequentially list conditions, if any, leading to immediate D	ue to (or as a conse	equence of):								+	
Cause. Enter Underlying Cause (Disease or injury that initiated c							+						
executed an and al - transit		events resulting in death) Last d.											
Lici be	edical	XUNPENDED	AMENDED 23a	a,PII,	27,28a-	f,per	cmE,	g89	8 12	/28/09	TT		
79						23d. Date of de Month	Day	Year					
Box e death co the atten ted for us	nysic	1 Yes 2 No 9 Unknown	4 Pregnant at g Unknown	time or deat	n 5 Othe	er (Specify,	)						
ires that the signed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Ohesity  Ohesity												
24a. Was an autopsy prior to compared autopsy performed?								y findings available					
							med? de	ath?	2 No				
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 V Other: Scene											
of V ing Phys After thi funeral di	<u>۱.</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 2	R/Outpatient 28b. Time of Inj			at Work?			now injury occurred		ne
ion (tending eath the fur	ation	1 Natural 5 Pending	(Month, Day,Y		Fd_3:40	am 1	Yes	s 2 X 1	No un	k			
Division tal or Attendi rs after death at Director: A	Certification:	2   Accident   Investigation   Suicide   Accident   Investigation   Suicide   Accident   Investigation   Accident   Investigation   Suicide   Accident   Investigation   Accident   Accident   Investigation   Accident   Accident   Investigation   Accident   Accident   Investigation   Accident   Accide							oute Number, City aks Ave				
To the Hospital or / within 24 hours after To the Funeral Directions completely filled in b		29a. Certifier 1 Certifying Physicia	n: To the best of m	y knowledge	e, death occurre	ed at the tin	ne, date	and plac	e, and du	e to the caus	e(s) and manner a	s stated.	
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.  29b. Signature and title of certifier 29c. License number 29d. E						29d. Date signed							
	December 10, 2009						,=./						
		30. Name and address of person who co		,	,	D-111		D 040-			1		
	ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32 Registrar's Signature											
Regist		BEC 16 ZUU		4	back	es							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 0646 **Physician** Dennis (, fr 1)00 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MM Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/06/1958 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min. Months 1 X M 2 □ F 51 214-78-9210 Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, it a Modical Evanings must be notified at 1 ☐ Yes 2X No Harford Aberdeen Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21001 244 Golf Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1页Yes 2☐ No Grand IfYes, Give 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married White Maryland 21215-0036 1 ☐Yes 2X No Specify If Yes, Give Year or Dates: 1974–1981 \$ 3 ₩ Widowed 4 Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental (unknown) Mabel Grover Pritt ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 Main Street, Delta, PA 17314 Daniel Pritt / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/14/2009 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall nustially PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herniatio Physician ran /Medical Due to (or as a consequence of): Examiner Hemosruage Intraceseusa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the the attending for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 NO 1 ☐ Yes 2 No certificate 1 □ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury Hospital or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □Yes 2 □No after death. Director: Af filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide 24 hours a Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2009 30. Name an address of passar who completed cause of death (Item 23a) (Type, Print) Baltimore. Crandell, ND 225. M. Kenneth 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 16 SAMA

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 2009

		1	For State C	Cer	rtificate of D		Reg	2009	40103	
	Physicia		1. Decedent's Name (First, Middle, Last)	PHETERSON	ı		2. Date of Death	P3, 2009	3. Time of Death 5:30 Å M	
	Medic	edical RTVA				4b. City, Town, or Location of Death  4c. County of De				
لبر	Examin	C1	LEVINDALE HEBREW HOME		BALTIM			N/A		
П	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth		rthplace (State or Foreign puntry) MD	
		l. H	Usual Residence of Decedent	10c. City, Town or Lo	ention				10d. Inside City Limits	
	a-f sho	Director	10a. State 10b. County	BALTIMORE					1 💢 Yes 2 □ No	
10	he Ma or 28a e notif		MD N/A  10e. Street and Number	DALTIMONE	10f. Zip Code		10	g. Citizen of What C	country?	
	with t	Funeral	7034 WALLIS AVENUE		21215			USA		
	death r item iner m		11. Marital Status 12. Was Dec Armed Fo	edent Ever in U.S. 13. Vorces? 13. Vo	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
920	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.  It is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	sd by	3 Midowed 4 Divorced If Yes, Giryear or D	ve l	1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE	
2-0	2 hour "natur idical	Completed	15. Decedent's Education (Specify only highest grade completed	) (Give	dent's Usual Occupa kind of work done d	ation Juring most of work	ing 1	6b. Kind of Business	s Industry	
121	within 72 giene. er than ' the Me	Som	Elementary/Seconday (0-12) College (12)	I=4 or 5+) life. D	ERY SCH00	I TEACHER		EDUCATIO	N	
d 2	iled wi I Hygid other ent, t	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma		EDMAN	
/lan	ld be fi Menta narked atic ev	잍	BENJAMIN	BLUMENTHA		EVA		*	EDMAN	
Maryland 21215-0036	shoul h and 7 is m raums		19a. Informant's Name/Relationship (Type, Print)					tity or Town, State, 2, MD 2120		
	and Heal em		CHERYL RUSS / DAUGHTER  20a. Method of Disposition	20b. Place of Dispo	osition (Name of			Oc. Location - City of		
mo	a. O 4m 5m		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	CHEVRA AL	matory or other plac HAVAS CHES	SED   12-1	5-2009	RANDALLST	OWN, MD	
Baltimore,	permit. Page Department o Important: If any injury or once,		21. Signature of Funeral Service Lightnesee	1/1 2	2. Name and Addres	s of Facility SOI	_ LEVINSO	N & BROTH	ERS, INC. MD 21208	
			23a. Part 1. Enter the disease, or complications that	caused the death. Do not ent					Approximate Interval Between	
	Pnysician/	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition								
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):							
	<b>L</b> AGIIIIO	er	Sequentially list conditions, b.	(or as a spinsequence of):	mo				16 mm	
1	rted d ansit						٠	7 bmonth		
p	icate be executed physician and s the burial-transit		resulting in death) Last  Due to (or as a consequence of):							
2092	cate be physic	<b>Nedical</b>	d							
89	ath certifica attending p	M/us	23b. was decedent pregnant	utcome of pregnancy	Ectopic pregnanc	CV		23d. Date of c		
Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/		gnant at time of death 5	Other (specify)			Month	Day Year	
P.O.	that the ned by detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?	
	v requires that s been signed k should be det	ted b					1 🗆 Yes		Probably 4 Denknown	
COL	law rec nas ber s 2 sho	Completed					24a. Was an autopsy perform	prior t	autopsy findings available o completion of cause of ?	
Re	ician; The law certificate has rector, page 2 s		25. Was case referred to medical		26 D	lace of Death (Oheo	1 🗆 Yes 2	No 1□Y	∕es 2 □ No	
/ita	Physician; T this certifica ral director, p	To Be	examiner? Hospital:	☐ Inpatient 2 ☐ ER/Outpatie	Oth	OF:		nce 6 Other (Sp	ecify)	
of	ding Phy h. After this funeral o		27, Manner of Death 28a. Dat	e of injury nth, Day, Year) 28b. Time of injury	of 28c. Injur	y at </td <td>28d. Describe hov</td> <td></td> <td></td>	28d. Describe hov			
ion	death. ctor: At y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, farm, st		Yes 2 □ No	28f Location (Stre	eet and Number or F	Rural Route Number,	
Division of Vital Records,	al or Attend s after death I Director: A d in by the f	Cer		ding, etc. (Specify)	treet, factory, emoc		City or Town,	State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fune	Medical	29a. Certifier 1 Certifying Physician: To the 2 Medical Examiner: On the b	asis of examination and/or inve	estigation, in my opini	on, death occurred a	at the time, date and	d place, and due to th	ne cause(s) and manner stated.	
7	To the within 2 To the comple	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)						nth, Day, Year)		
	)	Megani Mi) DEC.13						13.2009		
			30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print) Ball	rivere	L DIN	21211	13.2009	
	Sta		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	al S		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Ε. Price 11:10 A^M 2009 <u>December</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 1 **Funeral** Maryland Days 1 🗆 M 2 🔀 F Months Hours (Month, Day, 214-26-8816 85 Yrs Director <u>January</u> Usual Residence of Decedent | Hygiene. | other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Marvland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8101 Bellona Avenue 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Completed White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Home Maker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur C. Jones Christine Naylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sillery Bay Road, Pasadena, Maryland Thomas C. Price / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/21/2009 James Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Monkton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence off executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Day Month Year g Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform leral Director: After this certificate liflled in by the funeral director, page 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 5 Pending Natural Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier

Registrar

0

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

December 14 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death
1:20 A M 2. Date of Death Physician/ Medical Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Months Days Hours Min. Yrs. Director Usual Residence of Decedent shov 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 📉 No 28a-f 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a items ; а.п. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No )hite Specify: 1:20 "natural", Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 2009 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DECEMBER 13, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) man 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Addre Signature of Funeral Service Licenses Chapel PYCO 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death ₽πysician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death I signed by the a g 🗌 Unknown 9 Unknown MARIE PAYNE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** To the Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) **HOSPICE** 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🗆 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ttle of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and

Date filed (Mont)

JONES,

CRNP

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

7

TIMONIUM, MD 21093

Kikue Poynter	F	State of Maryland / Department of Health and Ment 1- For State Certificate of Death	tal Hygiene	Reg. No. 200	9 40108					
Physician Medical Examine	"	1. Decedent's Name (First, Middle,Last)  Kikue Poynter	2. Date of I Month <b>Decem</b>	Death Day Year ber 14, 2009	3. Time of Death 2136 hrs					
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Gilchrist Hospice  Towson		4c. County of Deat Baltimore Co						
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		f Birth(MM/DD/YYYY) 9. Bi	rthplace (State or					
Director	L	015-36-8925 1 Months Days Hours	Min. June	01,1930 c	^{gn} Yokohama, ^{puntry)} Japan					
aux	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
ne Maryland or 28a-f show fied at once.		Maryland Prince Georges Beltsville  10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	1 Yes 2 No					
# a = 1 5		11320 Evans Trail Apt.102 21705		United St						
ath with tems 23 st be no	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican, M			rican Indian, Black,					
after de	2 6 -	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Date:  1 Yes 2 No specify: 1 Yes 2 No specify:		Specify: J	apanese					
2 hours "natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business	/Industry					
Nithin 7 rene.	Completed	12 n/a Home Maker		Own	Home					
215-( be filed v trked oth ent, the		17. Father's Name (First, Middle, Last)  Unknown Kiryu Unknown		lle, Maiden Surname) Kirvu						
b 21, should be and Men Men Air is mar latic eve	<u> </u>	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Num	nber or Rural Route	Number, City or Town, Stat						
e, M I and 2 Health: item 2'		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	02 Beltsvil 20c. Location - City o						
Baltimore, MD 21215-0036 ermit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify:	Dec. 17 2009	Forest H	ill, Marylan					
Balf permit Depart Impor		21. Signature of Funeral Service Licensee  22. Name and Address of Facility PedCeful Altery 23.25 York Road	hatives F	uneral&Crema nium, Marvla	tion Ctr.,P.					
Physician /Medical		23a. Pan Enter the disease or complications that caused the death. Do not enter the mode of dying, such as c failure. List only one cause on each line.	ardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and					
Examiner	Ì	Immediate Cause (Final Mease or condition resulting in death)  a. Broncho neumonia  Due to (or as a consequence of):			Death					
<u> </u>		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-					
ted wingst		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			-					
that the death certificate be executed need by the attending physician and detached for use as the burial - transit by Dhyscician/Modifical Ex	<u>.</u>	d.		· · · · · ·						
. Box 68760, the death certificate be executed to the attending physician and teched for use as the burial - tra	Medic	IF FEMALE: 23a,PII,27,permE, g900, 2/	1/10 TT	23d. Date of delive	ry					
c 687 certific ending r use as th	Clan	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic	c pregnancy	Month	Day Year					
the death y the att	ly Si	1 Yes 2 ✓ No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	23e D	id tobacco use contribute t	o the cause of death?					
ires that the signed by signed by the detach	2	Hypertensive atherosclerotic cardiovascular di								
rds requ	biefe	dementia		utopsy prior to	eutopsy findings available completion of cause of					
tal Reco		25. Was case referred to medical 26.Place of Death	1 <b>✓</b> Y	erformed? death? les 2 No 1 V						
F Vital Physician r this certi al director		examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4	Nursing Home 5	Residence 6 Oth	er: Scene					
on of anding Plath.		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work		tibe how injury occurred						
Division os spiral or Attending to bours after death.  neral Director: After filled in by the fune for the form of the fune for the form of the form o		2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et		on (Street and Number or F	tural Route Number, City					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director, completely filled in by the		4 Homicide determined (Specify)								
To the He within 24 To the Fu completel	anica L	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated		date and place, and due to	the cause(s)					
2	≥   ?	29b. Signeture and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (M December 15, 2						
4	}	30. Name and address of person who completed cause of death (Item 23a)	ID 04004							
Stat	e	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M 31. Date The Tox 2005 32. Registrar's Structure	ID 21201							
Registra	ar	31. Date (Her Month 16y 2005) 32. Registrar's Schature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 14, 2009 РМ Thi Pham 5:35 Thi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 1 □ M 2 🛛 October 9 Vietnam Director 88 none Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Ho Chi Minh none none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130/1 Duy Tan, Phu Nhuan District none Vietnam within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 'natural", or 1 Never Married 2 Married ð 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify: 3 X Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Num Pham Lan Bui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12808 Murphy Grove Terrace, Clarksburg, Maryland 20871 Le Thi Lai /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) December 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Ind 17, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Conrestive Heart Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ☐ Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s been si should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛚 No Hospital 1 🗀 Yes ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ( 27. Manner of Death the Funeral Director: After th npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital 24 hours Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 December 15, 2009 D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, Maryland 20850 Saved Elsayyad, M.D.

State

Registrar

31. Date filed (Month, Day, Year)

DEC 16 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end 19b, per Inf C898 12/21/09 TT State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G901 3/09/2011 THE OF Death 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 13 Reaves hew 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Age (In vrs. last birthday) t**X**□M 2□F 215-76-6901 50 23,1959 Maryland 215 67 6991 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location X ☐ Yes 2 ☐ No Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin-Code USA 21216 984 Franklintown Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married SpeBylack 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Automotive Mechanic 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Jones Andrew Reaves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road, BAItimore, MD Joy McFadden-Reaves/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition /22/09 Cem. Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) Owings Mills, MD Garrison Forest ^{22. Name and Address of Facilit}Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore,MD 21215 21. Signature of Funeral Service License Farres 23a. Part. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart, illure. List only one cause on each line. Onset and Death Immediate Cause Final

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show her must be notified at

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"natural"

is marked other

permit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai

Director

by Funeral

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

g physician and as the burial-transit certificate has t director, page 2 s after death.

Director: A
d in by the f within 24 hours a

To the Funeral C

completely filled

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

resulting in death)	Due v in r as a conseq	uence of):			
Sequentially list conditions, if any, leading to him editate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)	,			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	Gc. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 🗌 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying.	ng cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?  2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	lospital: 1 💢 Inpatient 2 🗆	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 - Residence	6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1  Yes 2 No	28d. Describe how in	njury occurred
1 Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specit	ome, farm, street, fact	cory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 A Certifying Phys	ician: To the best of my kno ner: On the basis of examina and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	I im	4	RES- 000		Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

TIMI

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROShni

UEU 1 0 2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH C898 12/16/09 JH
State of Maryland / Department of Health and Mental Hygiene
1- For Amend 19a, per Inf C898 12.29.09 TT
Reg. No. 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician FAY ROSEN - 200 /Medical 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COURTLAND GARDENS BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/08/1920 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 👿 F Months Days Hours 499-05-5036 89 MO Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7920 SCOTTS LEVEL Funeral ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify. 2 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** 1 and 2 should be filed with and Mental Hygier and Mental Hygier marked other the CONSTRUCTION traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ISADORE FEDER** ပ SARAH TEPPER 19a. Informant's Name/Relationship (Type. Print) Ian Dennis
DENNIS RAPPORT / SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 9301 ANGELINA CIRCLE, COLUMBIA, MD 21045 20a. Method of Disposition

☐ Burlat 2 ☐ Crem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 2 Cremation 3 KRemoval from State 4 Donation 5 ☐ Other (Specify) CHEVRA KADISHA CEM 12/17/2009 UNIVERSITY CITY, MO 1. Signat e of Fu eral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner sequentially fet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of): Records, P.O, Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed Division or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After the Hospital or Attending hin 24 hours after death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24346 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ам Annie Mae Ragland 7, 8:00 2009 December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's St. Thomas More Nursing Center Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/23/1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F 80 North Carolina 239-52-1061 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show Examinary ust be notified at DC Washington 1KIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 115 Missouri Ave., NW 20011 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ∐Yes 2 INo If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 ▼ No Specify: Black Specify er than "natural", c þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, IT. A. Once. Private Cashier 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Babe Stanley Orilla Bell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type. Print) 6000 South Hill Mar Circle, District Heights, MD Valarie Hatcher - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/17/2009 Suitland, Maryland Washington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 20011 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Approximate Interval Between Onset and Death tions that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause or / ach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions Examine Due to for as a ponsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last I or Attending Physician: The law requires that the death certificate be executed after death.

Director. After this certificate has been signed by the attending physician and bir or by the Internal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 PNo 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Be Certification: To

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

	24a. Was an autopsy performed 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No						
h ((	Check only one)							
ome	5 Residence 6	Other (Specify)						
280	d. Describe how injury	occurred						
28f	Location (Street and City or Town, State)	Number or Rural Route Number,						

					12.00			
25. Was case referred to medical examiner?		26. Place of Death (Check only one)						
1 Yes 2	(No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of D at 1 Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a, Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and pon, in my opinion, death o	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)			

29b.	Signature	and title	of certific		
	-			1	 
	lana and			uha cama	 o of dooth /Itom

29c. License number

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

Ajit Kurup, MD, 4922 Lasalle Rd, Hyattsville, Md 20782 31. Date filed (Manual) Pay, Year)

State Registrar

thin 24 hours aft the Funeral Di mpletely filled in

within 2

Medical

PAR

State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December To, 2009 Thomas Benedict Roche 12:46 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3143 Brooklawn Terrace Chevy Chase  ${ t Montgomery}$ Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 🕅 M 2 □ F Davs Min. **Director** .57-24-0284 77 New_ March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene then "natural", or items 23a or 28a-f sho ritem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Chevy Chase 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3143 Brooklawn Terrace 20815 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Systems Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Roche Ellen Cawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jessica E. Roche/Daughter 3143 Brooklawn Terrace, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State December 15, St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hamilton, New Jersey 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 7 Years Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Prostate Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2X No 2 🗌 No 1 \sum Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🔀 No 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this Luter death.

*I Director; After the 'in by the fire 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0043361 December 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert S. Siegel, M.D. 2150 Pennsylvania Avenue, N.W., Washington, D.C 20037 1 6 2005 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40112 State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15,2009 Randolph Barry Sayre December 2:07 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson 8. Date of Birth
(Month, Day, Year)
AUG _ 12,1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 1Ж M 2 □ F Months Min. Hours 232-64-3271 Huntington, W. VA Director 66 Yrs 1943 Usual Residence of Decedent show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Baltimore County Timonium 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 80 E. Padonia Road Apt.102 21093 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 Married 1X Yes 2 □ No If Yes, Give Year or Dates. Vietnam Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify. 'natural", 3 Widowed 4 Divorced Completed Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 02 Optician Co-Optics, Inc. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Eugene Sayre Ruby Eleanor Cyrus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Theresa Ann Sayre (Daughter) 2960 Etchison Road Lot#7 Loganville, GA. 30052 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 D Removal from State cemetery, crematory or other place) Dec. 16, Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2009 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses 23a. Fert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cana Medical Due to (or as a consulence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? this certificate 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) Man R149194 Deartu 15,2009

321

State

Registrar

57

Towson,

MD 21204

N. Chales

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grant

31. Date filed (Month, Day,

DEC 16 2009

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g898 12-23-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day :30PM torace -2009 /Medical 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memoria 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) 24 Hrs 9. Birthplace (State or Foreign **Funeral** 241-48-2134 1 M 2 □ F Months Hours Min Director -29-1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiting roughbar notified at 10d. Inside City Limits 1 Yes 2 No Director Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban_Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ₩idowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event. It is Imany injury or other traumatic event. Elementary/Secondary (1-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surnam ပ 19a. Informant's 19b. Mailing Address (Street and Number or Fural Route Numl or Town, State, Zip Code) Sister 10. 20b. Place of Disposition (Name of cemetery, crematory or other place) of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Balto.MD 4 □ Donation 5 □ Other (Specify) 49-09 21. Signature of Funeral Service Licensee C. Greene Funeral Services 5151 Balto. Nat4 Balto MD 21229 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory irrest, shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Disean 1286 money disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ungertine Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed mound and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen: Jhn 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 □ Yes 2 □ № 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 31464 12/14/68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inite 308 BALTIMORE on 2120 Hasismi \$21 N. Entaw St

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

(11)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Marylands Repartment of Dooth For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Georgia Shear Physician/ Lee December 6, 2009^{ar} 4:51 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Months Sept D30 (ear) 1958 Mary Tand 51 217-64-0029 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🕅 No MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 133 Marburth Avenue 21286 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) N/A Dependant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Shear Jacqueline Elizabeth Travers Sidney George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1038 W. Seminary Ave., Lutherville, MD 21093 Leslie A. Shear-sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 1 X Burial 2 Cremation 3 Removal from State 12/9/09 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service See William G. Dau 1050 York Rd., Towson, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ementia roa disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an affer death. I Director: After this certificate has b المناقبة بالمناقبة المناقبة ا autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence thronce Certificate: To 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 2 🗌 No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier The control of the desire of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the I within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R145356 December 15,2009 Tula C Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Towson MD 21200 West 31. Date filed (Month, Day Year) 32. Registrar's Signatur State 16

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 5:00 AM **Physician** 2009 Decembe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Daltimore Square 6. Sex Rosedale Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 220-36-07 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F q Director Usual Residence of Decedent 10d. Inside City Limite 10c. City, Town or Location 10b County 28a-f shov 1 ☐Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 122 UNITED Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No ö Specify Specify: WHITE 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Jonge. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BRIVE BALTIMORE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatitis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experience) Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DECEMBER, 11,2000 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nam

State Registrar

Registrar 2000 1 0 2000

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		ent of Hea cate of De			jiene leg. No. 2	9 60116
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day Year	3. Time of Death
-	/Medi		Robert King Steve					Decembe	r 13 200	19 1:05 PM
ar.	Examin Funeral Director	er	5. Social Security Number 6.	Mare Hospi	tal	nder 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day Feb. 24,	4c. County of Dea 13 4 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	th  Tho re  Thiplace (State or Foreign ountry)  Linore, MD.
	pue w		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Location					10d. Inside City Limits
	f shore	ō								1 ☐ Yes 2 ♣ No
	the N	Director	10e. Street and Number	re county Pe	rry Hall	. Zip Code		1	0g. Citizen of What C	ountry?
	h with		7 Brook Farm Cour	t Unit L			128		United St	•
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show officel Examinat must be retified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 1 3	If Yes,	ecedent of Hispar specify Cuban, M		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within ene. <b>than</b> "	Completed	15. Decedent's En (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	life. DO NO	Usual Occupation f work done during T use retired)	g most of working	99	16b. Kind of Business	Industry
Maryland 2	be filec Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last, John Stevenson		111000	18.			Jing 1 Maiden Surname)	
ary	shd and sm		19a. Informant's Name/Relationship (	Type Print) (wife)	19b. Mailing Add	ress (Street and I	Number or Rura	l Route Number	r, City or Town, State,	Zip Code)
	다 등 등 다		Cheryl Ziolkowski			Farm Co		nit L		1,MD. 21128
more	Pages 1 ar nent of Hear int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	THE HOLL OLD CARE	Place of Disposition cemetery, crematory	(Name of or other place) 11 Chave	Dec.	15.	20c. Location - City or	Town, State Hill, Maryland
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.	) 1 ) 2	21. Signature of Funeral Service Licer	"		-	1 2.0	09   es Funer Monium,		ion Ctr.,P.A. 21093
			23a. Part . Enter the disease, or com short, or heart failure. List only	plications that caused the death	h. Do not enter the	mode of dying, su	uch as cardiac o	r respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Respira	tory 1	trrest	-			Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence b) Due to (or as a consequence b)	2an S	ystem	Fai	ilure		
1	rtificate be executed ng physician and as the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. UNOSED Due to (or as a consequence)	SIS uence of):	N A	C			
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rds, P.	w requires that t s been signed by s should be deta	5	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlyi	ng cause given in	Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Reco	e law rec has bee je 2 shor	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
<u>e</u>	ician; The lav certificate has ector, page 2.		DE Mon construction and incl					1 □ Yes	2 No 1 □ Ye	s 2 No
S	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	Other	Place of Death		e) ence 6 □Other (Spe	
on of	ling Phy I. After thi funeral o	ion: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	2		ow injury occurred	ecity)
Division of Vital Records,	or Attency after death Director: d in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		me, farm, street, fac y)	1 ☐ Yes		8f. Location (St City or Town	reet and Number or R n, State)	tural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 dical Example	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occu tion and/or investiga	rred at the time, d tion, in my opinio	late and place, a on, death occurre	and due to the c ed at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	withii Comp	ž	29b. Signature and title of certifier		Ио	29c. License nur	mber	2	9d. Date signed (Mon	th, Day, Year)
	1.1		D 84-10	A WILL	No	Res	5000	00	Decembe	r 13, 2009
	10×1	-	30. Name and address of person who	1000 FEANKli	1 Zoa) (Type, Print)	c. Drive	, Pral	to. M	d 7.12:	37
	Star Registra	_	31. Date filed (Month, Day, Year)	32. Jegistrar's Signa	ture Jack				-,	1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan W. Spicer 2009 3:45 P.M December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. Country) 219-28-9767 78 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Medical Examiner must be notified at Director Lutherville Baltimore Maryland 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States Funeral 21093 items 23a 1401 Alston Court of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian. 11. Marital Status Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No white 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mean joines. College (1-4 or 5+) Maryland 2121 Elementary/Seconday (0-12) Teacher Public Schools Be 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Good 17. Father's Name (First, Middle, Last) 0 John F. Williams Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Mr. Richard T. Spicer/husband 1401 Alston Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 State (Specify Intomicinal cemetery, crematory or other place) December Lorraine Park Cem. 18, 2009 Baltimore, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licens 23a. Part 1. Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading time state cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a conse uence of) Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. been signed by the attending physician and should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

3.45

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12/21

NOH

SUITE 4105 BALTIMOREIMS 21204

6701

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 2009

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla	and / Dep	artment of	Health ai	nd Mental Hy	giene			
	_		State Registrar		Ce	rtificate of	Death		Reg. No. 200	9	40	118
P	hysicia	an/	1. Decedent's Name (First, Middle, Last)	Maria Sard	ما ام			2. Date of De Month			. Time of I	Death
	Medi	cal	4a. Facility Name (if not institution, give str		CIId			Decemb	er 15, 200	09	1:34	A. ^M
	Examir	ıer	Gilchrist Hospi			4b. City, Town,		Death	4c. County of D			
F	uneral	_	5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year		Hrs. 8, Date of Bir		Birthplace	State or	Foreign
	rector			м 2₺₽	64 Yrs.	Months Days	Hours	Min. Month De		Country)	Mary.	land
Þ	at.	Ļ	Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Le	neation						
arylar	a-f s ified	ecto	Maryland N/A	100.0	•	inore					Inside City	-
the M	or 28 e not	ä	10e. Street and Number			10f. Zip Code			10g Citizen of What		1 22 103	2 110
with	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	6135 Parkway Dri	.ve		21	212		of Amer			
death	item ner m			2. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I		? (Specify Yes or No-	14. Race - A	merican Ir	ndian,	
36 after	al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2ŽŽŠNo If Yes, Give		1 ☐ Yes 2/5 No		derto riicari, etc.,	Black, W Specify:	White, etc.	e	
hours	atura ical E	Completed	15. Decedent's Educ	Year or Dates.	16a, Dece	dent's Usual Occu	nation					
21.0 in 72	nan "r Med	d m	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	(Give	kind of work done O NOT use retired	durina most of	f working	16b. Kind of Busine	ess Industr	у	
2 with	her th	ŏ	12	5		Therapis	t.		Thera	ару		
<b>Baltimore, Maryland 21215-0036</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	arked ot itic ever	To Be	17. Father's Name (First, Middle, Last) Guy V. Sar	della				Name (First, Middle, Cia DeLeon				
Man Shoul	' is ma rauma		19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number o	or Rural Route Numbe	r, City or Town, State,	Zip Code)	)	
e, N and 2 Health	em 27 ther t		Mr. Louis M. Sarde				Crysta	al Bay, Ne				
nor age 1 ent of	nt: If it y or o		1 Burial 2 Cremation 3 Re	moval from State E	vantsy, pre	osition (Name of matery or other pla		eceliber	20c. Location - City			
<b>Saltimore,</b> permit. Page 1 and Department of Hea	oortar injur		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Pervice Licensee			Bel Air		LE, 2009	Forest Hi			
De la <b>c</b>	a a		1 Motato B	Alf.	PE	aceful A 2325 Yor	Iternat k Road	ives Fune Timoniu	ral &Crema m, Marylar	ation nd 21	ogtr.	.,P.A
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e law	age 2	Completed						— 24a. Was a autop perfor	sy prior t	o completi	ion of cau	se of
ian: T	runs cerunicate nat aral director, page 2		25. Was case referred to medical			26. PI	ace of Death ((	1 🗌 Yes Check only one)	2 <b>X</b> No. 1 □ 1	Yes 2 🗆	No	- 21
VIL hysici	direc	일	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	Oth	ar.	ng Home 5 Reside	ence 6 Nother (Sp.	ecify) /	24 DE	-
ing P	unera	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	/ at		w injury occurred		31	_
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al or A	din	ပ၂	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, tarm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route	Number,	
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the lithin 2	эшры	— г	only one) 3 Certifying Nurse Po	ractioner: To the best of m	ny knowledge, c	eath occurred at the	e time, date and	place, and due to the	cause(s) and manner a	as stated.		er stated.
F= ≥ F=	- 5		1 Olyentun			29c. License	5930		9d. Date signed (Mor			;
	$\cap$		30. Name and address of person who comp	eleted cause of death (Item	n 23a) (Type, P	rint)	-0-0	ر	N MD	J -		
,	10		Apon J CHAZU	E MD 6	701 N	oller	les Ji	1 Jourso	M MD			
Re	State egistra		31. Date filed (Month, Day, Year) 2009	32. Registrar's Signa	iture	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 December 7:50 A M Vallabhbhai Sakhawala Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19217 Wheatfield Drive Germantown Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. August 4, 1934 Director India 218-55-4572 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19217 Wheatfield Drive 20876 India Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ģ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian-Indian 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi of Health and Mental item 27 is marked မ Nanjibhai A. Sakhawala Devben Borad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mansuk Sakhawala/Son 19217 Wheatfield Drive, Germantown, MD 20876 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State Montgomery Crematorium, 4 Donation 5 Other (Specify) 10, 2009 Inc. Dec. Bethesda, Maryland 22 Name and Address of Facility Robert A. Pumphrey Home/Bethesda—Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses 4 anon M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Non Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exam Due to (or as a consequence of) Physician/Medical death certificate be phy: the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2X No page 2 s certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 24 hours a the Hospital Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland

68760

Box

P.0.

Records,

**Division of Vital** 

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

M.D.,

Ram Trehan, 31. Date filed (Month, Day, Year) D33224

1400 Forest Glen Rd. #435, Silver Spring, Maryland 20901

December 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department	artment of Health and N tificate of Death		2000 1.0120
			Registrar  1. Decedent's Name (First, Middle, Last)	uncate of Death	Reg. I	3. Time of Death
	Physicia Medio		HANNAH STEIN	,	DECEMBER	
, i	Examin		4a. Facility Name (if not institution, give street and number)  FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK	4	4c. County of Death FREDERICK
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	Birthplace (State or Foreign
	Director		132 - 03 - 6261 1 M 2 V F 89 Yrs.	Worldis Days Hours Will.	(Month, Day, Year 03/18/192	O NY
	and show	힏	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary 28a-f otifie	Director	NY SUFFOLK MEDFO			1 ☐ Yes XX No
	ith the		10e. Street and Number	10f. Zip Code 11763	10g.	Citizen of What Country?
	tems er mu	Funeral	18 ROBINSON AVENUE  11. Marital Status  12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
36	s filed within 72 hours after death with the Maryland fal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 No	if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🙀 No Specify:	nicali, etc.)	Black, White, etc.  Specify: WHITE
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Maryland	ould be file Ind Mental Imarked c	잍	LOUIS BENJAMIN	SARAH		SEVEL
Mar	1 and 2 shou f Health and item 27 is rr other traum			ng Address (Street and Number or Run BINSON AVENUE, ME	-	
			20a. Method of Disposition 20b. Place of Dispo			. Location - City or Town, State
altimore,	Page ment o tant: If ury or		4 Donation 5 Other (Specify)  BETH OLAM	MEM.PARK 12/1	4/2009 LAK	
Balt	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licenson 2	2. Name and Address of Facility SOL 900 REISTERSTOWN	LEVINSON ROAD, PIKE	& BROS., INC. SVILLE, MD 21208
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		7/4	Approximate Interval Between
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	sit sd	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or initiury			
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09	ate be executed physician and the burial-transi	dical				
	ertifica ding pl	/Me	IF FEMALE: 23b, Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
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P.O. E	at the c d by th etache		g Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tobacc	to use contribute to the cause of death?
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ord	aw requas beer 2 shou	plete	Hypertension		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec	The law cate has		Congestive heart fa	lure	performed 1 Yes 2	death? No 1 ☐ Yes 2 No
ital	ysician: The is certificate director, pag	m	25. Was case referred to medical examiner?  1 X Yes 2 □ No  Hospital:  1 □ Inpatient 2 X ER/Outpatie	26. Place of Death (Chec		6 ☐ Other (Specify)
of \	ding Phys th. After this funeral di	te: To	27. Manner of Death 28a. Date of injury Natural 5 Pending    Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pendi		28d. Describe how in	
ion	ttendir death. Stor: Af y the fu	Certificate:	2 Accident Investigation	M 1 Yes 2 No	206 Lagation Change	and Number or Rural Route Number,
Division of Vital Records,	al or Attends after death Director; of in by the i		4 Homicide determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	eer, ractory, onice	City or Town, Sta	
<u>-</u>	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Medical	29a. Certifier  (Check (Check only one)  1 Certifying Physician: To the best of my knowledge, death only one)  3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	it the time, date and pla	ace, and due to the cause(s) and manner stated.
1	To the within To the compl	Σ	only one) 3 $\square$ <b>Certifying Nurse Practioner</b> : To the best of my knowledge, 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	•		· Celan Kohres de DME	D37197	Dac	ember 13, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Alan Kohrev and DME 15 We	of TEStrant	Frederi	ck, MD Zi 701
	Sta Registr		31. Date filed (Month, Day, Year) 33 Registrar's Signature	and the second		
	Hogioti	ш,	11FL & U 6999 ( LEWY C. 208	Week.		

09-09688 Shannahan

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 13, 2009 1225 hrs **Medical Examiner** Shanahan Leo Paul 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Pasadena 1270 Holmespun Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Maryland Min. Months Days Hours Director May 3, 1962 216-96-0099 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No s 23a or 28a-f show a Baltimore N/A Maryland Baltimore, MD 21215-UU30
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht
injury or other fraumatic event, the Medical Examiner must be notified at one Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21223 1329 Herkimer Street 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Office Supply Printer 12 N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Μ. Saxton Shanahan, Sr. Della Be John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2030 Kurtz Avenue Pasadena, Maryland 21122 Della M. Shanahan (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland Atlantic Cremation 12/18/09 Donation 5 Other Specify: 2. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of uneral Service Licensee Approximate Interval at I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Madical Methadone and alcohol intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner ause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and tran. Physician/Medical X UNPENDED AMENDED signed by the attending physician be detached for use as the burial 23a,27,28a-f,permE, g8999 1/22/10 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 ✔ No 3 Probably 4 Unknown 2 Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient this I dir 1 ✓ Yes 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) Natural Yes 2X No unk neral Director: filled in by the f Pending 24 hours after death 12/13/10 FD 12:00 pm Investigation Accident 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1270 Holmespun Dr 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide found at home Pasadena, MD determined within 24 hours a To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 14, 2009 O.C.M.E. -1mm 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year, State 6_2009 Registrar

DHMH 17 Rev 1/2001

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:30 P M Stevenson hompson-December /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Frankford N Baltimore If Under 24 Rehabilitation Maryland ursing . Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days Min 1 □ M 2 🗙 F 0672171959 Baltimore, MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Cockeysville MD Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 21030 10g. Citizen of What Country? 10e. Street and Number 17 Bridgelake Circle Apt. F by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 ☐ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Inemer Charles Barbour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Bridgelake Circle Apt. F Charles Barbour/ father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2009 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road, Towson, MD Unyl 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Circhosis /Medical Due to (or as a consequence of): Examiner Henatik's 10 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tran attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year DEC 16 2005

821 N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrars Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \begin{align*} \be For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 December 8. 12:20 P M Berger Thomas June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Yea July 26, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🔯 Hours Washington, D. C. 579-34-4472 80 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 🗓 No Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20853 United States 4504 Glasgow Drive death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hyglene. 7 is marked other than "r United States Elementary/Seconday (0-12) 12 College (1-4 or 5+) Government Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mahe1 Horton Charles F. Berger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 31, 15715 Barnesville Road, Boyds, Maryland 20841 L. Kelley/ Daughter Kathleen Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State December Silver Spring, Maryland Gate Of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. lette Barry 20850-2805 M01305 300 West Montgomery Avenue, Rockville, Maryland 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Respiratory Arrest Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury District or as a consequence of Exami burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 ∐ Yes 2 ≝ g ☐ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Division of Vital Records, Hypertension Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate has performed?
1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖺 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours are death

To the Funeral Director A
completed filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and titl

Maria J. Tayag, M.D.

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

Butch

D63579

1500 Forest Glen Road, Silver Spring, Maryland 20910

December 6, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fb 8898 12-16-09 vt State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician/ Month DUSEY TARTAKUVSKY MÁ 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7080 CRADLEROCK WAY, #612 COLUMBIA HOWARD 9. Birthplace (State or Foreign Country) UKRAINE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 X M 2 □ F **Funeral** Months Days Hours Min. 0971871915 94 Director 215-33-3161 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 7080 CRADLEROCK WAY, #612 21045 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married ò Completed by Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) TEACHER **EDUCATION** nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ -MOYSEY- MOYSHE TARTAKOVSKY **GERSH** H00VA TARTAKOVSKAYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : EDWARD TARKOVSKY / SON 352 BONNIE MEADOW CIRCLE, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 12/14/2009 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ACUTE RENK FAILURE Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ONGESTIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit OROWARY ANTER that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 4 Pregnant a 9 Unknown sate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform or Attending Physician: The this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Virginia Van Hollen 20Ö9 <u>December</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 18 Treeway Ct. Apt. Baltimore Cowson Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, **Director** 88 2**16-1**4-4860 December 8. Usual Residence of Decedent 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21286 18 Treeway Court, Apt. 2B U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Health and Mental Hygiene. tem 27 is marked other than "natul other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) The Archdiocese of Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Myrtle Eckert Henry Louis Ruppert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Bedford St., Cumberland, MD 21502 Louis Van Hollen, Jr. Son Department of Health Important: If item 27 any injury or other the 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Hilltop Service Corp. 12/16/2009 Towson, Maryland 5 Other (Specify) 4 Donation Pineral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign tur 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line letestate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 pronths? Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 Probably 4 Unknown cate has been significant page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be determined

within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in a proper 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier

State Registrar

0

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day :13PM 12 09 Patricia Colleen Vaught 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death KOSEdale If Under 1 Year | If Under 24 Hrs. Baltimore Hespita ranklin Mare Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Year) Days 1 ☐ M 2 🔀 F Nov. 1, 1956 Maryland 215-68-5577 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ☐ Yes 21/21×10 Maryland Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1 Bagley Street 21047 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Genevieve McKeldin Daniel William Creevey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christopher J. Vaught / Husband 1 Bagley Street Fallson, Maryland 21047 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Evans Funeral Chapel 20c. Location - City or Town, State Dec. 16 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bel Air Forest Hill, Maryland Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, MD 21050 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ye on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Immediate Cause (Final etastatic Brast disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Lino Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ngs available of cause of

**Physician** /Medical Examiner

Department of Health a Important: If item 27 is any injury or other tra once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Funeral** 

Director

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "Ite Madical Examinat mast be notified at

vaught, Patricia

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

Pages 1

physician and s the burial-trans attending p ed by the a s been signed be should be deta

cate has by page 2 s certificate

certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

					1 ☐ Yes 2 [	]No 3∏ Probably 4☑10nkr
					24a. Was an autopsy performed?	24b. Were autopsy findings avair prior to completion of cause death? 1 □ Yes 2 □ No
5. Was case referred to me	edical			26. Place of D	eath (Check only one)	
examiner? 1∐ Yes 2☐ No	Н	ospital: Inpatient 2 🗆	ER/Outpatient 3 🗆	DOA Other: 4 Nursing	Home 5 ☐ Residence €	3 ☐ Other (Specify)
	ending envestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury	y occurred
	ould not be etermined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
		sician: To the best of my kno ner: On the basis of examina				and manner as stated. I place, and due to the cause(s)

12

State Registrar

29b. Signature and title of gertifier

MD

29c. License number

29d. Date signed (Month, Day, Year)

D0062573

12/11/09

30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

Square Drive, Baltimore, MD 2123 MD, 4000 Franklin Debrutlytiens 31. Date filed (Month, Day, Year)

DEC 16 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 14, 2009 David Winfred Wasson Jr. 6:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/24/1961 7. Age (In yrs. last birthday **Funeral** 1 M 2 🗆 F 237-13-5855 Hours 48 Director MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medic I Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3417 Nova Scotia Road 21001 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married ₹ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Mae Bradshaw David Charles Wasson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 B Weiner Ave., Harrington, DE 19952 Lacey Mae Wasson / Daughter 1 and 2 s of Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/16/2009 Woodbine, MD 4 Donation 5 Other (Specify) Final Journey Crem. 21. Signature of Funeral Service Licence Dorota Marshall Name and Address of Facility
Maryland Cremation Services Marshort PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications Human Immunodelicierco disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to increasing cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a son sequence or). Due to (or as a consequence of) resulting in death) Last sician a Physician/Medical Physician: The law requires that the death certificate be attending physi basson IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year g 🖂 Unknown ate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available 24a. Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🗖 No |6 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 12149194 December 15,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles. Marian Grant Towson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Detedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore City Senior Living If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 03/20/1937 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday **Funeral** 1□ M 2 1 F 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 **2**Yes 2 □ No Director Baltimore MD N/A10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3855 Greenspring Avenue 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: þ 3 XWidowed 4 ☐ Divorced Black Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Technician Northrup Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Samuel Booker Jr. Pitts Oueenie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 Auchentoroly Terrace Balto., MD 21217 Cypress(Daughter) Donna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 H Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 12/19/09 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD Ciamo 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITH 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be execu P.O. Box 68760. attending p as ed by the a signed I Division or Vital Records, has page 2 To the Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and physician the this certificate within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Street Baltimore Maryland

29b. Signature and title of certifiern M() 29c. License number 135102 29d. Date signed (Month, Day, Year) DECEMBER 15, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North CHarles 5901 DON

31. Date filed (Month, Day, Year) UEU 10 2009

29a. Certifier

(Check only one)

Medical

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Helena E. Wilmore 9:30 A. M December 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5206 Brookwood Road Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 1 □ M 2 🗶 F Maryland 218 06 2782 39 03/29/1970 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 🕱 No Anne Arundel Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5206 Brookwood Road 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician MD. General Hospital 3 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Hirschowitz Helen Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Wilmore / Husband 5206 Brookwood Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 12/15/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 ranewoush 23a. Part1. Enter the disease, o complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) Cal Due to (or as a consequence of): Sequentially list conditions, if any beautiful timms list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

Physician

/Medical

**Examiner** 

Director

by Funeral

Completed

Be

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**Funeral** 

**Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, It a Medical Exaction or must be rediffied at

Baltimore, Maryland 21215-0036

Examiner signed by the attending physician and it be detached for use as the burial-tran Physician/Medical Completed by within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

peen

has

this certificate

within 24 hours a To the Funerai L

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 → ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 1 ☐ Yes 2 Z No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 **No** 

25. Was case referred to medical examiner? 1 | Yes 2 | □ N6 27. Manner of Death 1 Natural

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 1 ☐Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

29a. Certifier

hot

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title Name and address of person

eted cause of death (Item 23a) (Type, Pint)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registra Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ FOI	oartment of Health and Nertificate of Death	, ,	ne No2009 40130
Physicia	an/	1. Decedent's Name (First, Middle, Last)  Kenneth Elwood Wise,	Sr.	2. Date of Death Month December	3. Time of Death
Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December	4c. County of Death
		Holy Cross Hospital	Silver Spring		Montgomery
Funeral Director			) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea September 1	9. Birthplace (State or Foreign Country) Maryland
d t	l,	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
arylan a-f sh fied a	cto				1 🔀 Yes 2 🗆 No
the Misson 28	Funeral Director	Maryland   Montgomery   Rocky   10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
with 1 s 23a ust b	eral	1003 Curtis Place	20852	τ	Jnited States
death items		Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Iryland 21215-0036  build be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give WWII Year or Dates.	1 ☐ Yes 2 🎇 No Specify:		Specify: White
5-00 hours 'natur dical l	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	ing 16	b. Kind of Business Industry
hin 72 ne. than "	mo.	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)		Self Employed
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lan be file lental rked c	[2	Martin I. Wise	B.	ve Mossbur	
ary should and M is ma			iling Address (Street and Number or Rura		
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Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o amy hijury or other traumatic event, the Medical Examance.		I Dulia Z Li Ciellation 3 — nemovaritoti state I	ematory or other place) Decei	mber	c. Location - City or Town, State
Baltimo permit. Page Department of Important: If any injury or once.			Crematorium, Inc. 16,		Bethesda, Maryland
Den Den any	1	I Was a Residence of the Residence of th	22, Name and Address of Facility Cobert A. Pumphrey Fune: 100 West Montgomery Ave	ral Home/Roo nue. Rockvil	ckville, Inc. lle, Maryland 20850-2805
		23a. Part 1/Inter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.			Approximate Interval Between
Physician/	9	Immediate Cause (Final   disease or condition   Gastrointestina	1 Bleeding		Onset and Death
Medical Examiner		resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):			1
	je	Sequentially list conditions, if any, ladding to immediate cause. Enter Underlying	lsm		
uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c. Coronary Artery	Disease		
ox 68760 ath certificate be executed attending physician and for use as the burial-transit	a EX	resulting in death) Last Due to (or as a consequence of):			
760 cate be physic the bi	edical	d	-1.		
68 certific nding use as	W/L	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box death c he atten	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O. I that the med by the e detache		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e Did tohac	co use contribute to the cause of death?
ords, P.O. Be requires that the de been signed by the should be detached	d by	Chronic Kidney Disease			2 □ No 3 □ Probably 4 🖾 Unknown
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed			24a. Was an	24b. Were autopsy findings available
<b>fital Reco</b> sician: The law r certificate has b irector, page 2 s	l mo			autopsy performed 1 \square Yes 2 \square	
(ital Fisician: Tiscian: Tisci	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec		
f Vij Physic this oc al dire	2	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of injury 28b. Time			e 6 Other (Specify)
sion of ttending P death. stor: After / the funer	cate	1 🔀 Natural 5 Dending (Month, Day, Year) 1 Pending 2 Accident Investigation		28d. Describe how i	injury occurred
iSio Atten er dear ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s			et and Number or Rural Route Number,
Div ital or irs afte al Dir led in	S	building, etc. (Specify)		City or Town, S	
the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred a	it the time, date and p	place, and due to the cause(s) and manner stated.
To the I	Σ	only one) 3 Li Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
		De Patel Jayant. M.D.	D00525	86	12/13/09
		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		-1 and 20010
Sta	oto.	Jayantil Patel, M.D. 1500 Forest G1 31. Date filed (Magth, Day, Year) / 32. Registrar's Signature	en koad, Silver Sp	ring, Mar	yrand 20910
Registi		I I I I I I I I I I I I I I I I I I I	Ked		

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		1	For State of M	-	epartment of H De <i>rtificate of D</i>			ene g. No. 2009	40131
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Cannon W	ratten		2. Date of Death Month December	c ^{Day} 2, 2009	3. Time of Death 8:42 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	Callion W		Location of Death	Весемьет	4c. County of Death	
			Suburban Hospital		Bethe:	sda If Under 24 Hrs.	8. Date of Birth	Montgom	ery place (State or Foreign
	Funeral Director		579-30-0648 ¹ ∑M 2□F	ge (In yrs. last birthda 80 Yrs	Months Days	Hours Min.	(Month, Day, You December 2	(ear) 1928 A1	ntry) abama
	nd thow at	'n	Usual Residence of Decedent           10a. State         10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	Maryla 18a-f s tified	rect	Maryland Montgomery	Roc	kville				1 🕅 Yes 2 🗆 No
	h the l	al Di	10e. Street and Number		10f. Zip Code	2051	10	g. Citizen of What Cou	
	ath wit	Funeral Director	401 Twinbrook Parkway  11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of Hi	0851 spanic Origin? (Spe	ecify Yes or No-	United St.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	P P	Armed Forces?  1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □	?	If Yes, specify Cuba  1 ☐ Yes 2 🔀 No	n, Mexican, Puerto	Rican, etc.)	Black, White	
5	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of B (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of B						6b. Kind of Business In	ndustry	
72	/ithin 7 iene. r than the M	Completed	Elementary/Seconday (0-12) College (1-4 or 1	(5+)	fe. DO NOT use retired) sistant Pos	tmaster		Postal Ser	vice
b	filed w al Hyg d othe event,	) Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
yla	uld be I Ment narke natic	잍	Joseph Berry Wratten			Mildred		Lewis	Contal
Maryland	12 sho ilth and 27 Is r r traun		19a. Informant's Name/Relationship (Type, Print)  Rachel J. Wratten / Wife	l l	Mailing Address (Street a				
Jre,	of Hea of Hea fitem		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from Stat	20b. Place of D	Disposition (Name of crematory or other place			0c. Location - City or	
Baltimore,	t. Page tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		ry Crematorium	n, Inc 16,	2009	Bethesda,	
Ba	permit Depar Impor any in		the feet of the first	м01305					nd 20850-2805
			23a. Part 1 Inter the disease, or complications that cause shock, or heart failure. List only one cause on each list Immediate Cause (Final	ne.		g, such as cardiac (	or respiratory arrest	t,	Approximate Interval Between Onset and Death
ر	Medical Examiner		disease or conditionaIntrac	cranial He s a consequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e a son sequence of)					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c	s a consequence of)	:				
8	te be e lysicial ne buri	edical	d						
987	ertificar ding ph	/Me	IF FEMALE: 23c. If yes, outcom	ne of pregnancy				23d. Date of deli	von
Division of Vital Records, P.O. Box 68760	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending it the Funeral Director. After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	n 2 Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Ey	<u>-</u>	Month	Day Year
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ecord	e law requ has beer ge 2 shou	Completed					24a. Was an autopsy perform	prior to death?	opsy findings available completion of cause of
چ س	an: The tificate tor, pay	Be Co	25. Was case referred to medical		26. P	ace of Death (Chec	1  Yes 2 k only one)	X No 1 Yes	2 🗆 No
Zit.	hysici his cer I direc	10 B		atient 2 ER/Outp		4 ☐ Nursing H		nce 6 Other (Speci	fy)
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ivisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farn etc. (Specify)	n, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
N N	e Hospita 124 hours 5 Funeral leted filled	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Certifying Nurse Practioner: To the Certifying Nurse Practioner: To the Certifying Nurse Practioner:	f examination and/or i	investigation, in my opini	on, death occurred a	it the time, date and	l place, and due to the o	cause(s) and manner stated.
11	To the within To the comp	2	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Month	
	)		Inde Worg	Frank (harra 2021) T	(no Brint)	D660	66	10/	13/09
			30. Name and address of person who completed cause of	23a (Item 23a) (Iy		d Georget	own Road	, Bethesda	, MD 20814
ı	Sta Registr			strar's Signature	ald				

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amend 1tem 30 per dvr e898 12-16-09 vt
State of Maryland Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Logation of Death 4c. County of Death Examiner Subur 09 mos 5 a-NS Q ひってつ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number Funeral Min. 1 □ M 2 🛛 F Months Days Hours Director 1/04/1946 MD 212-50-0011 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 V No ΜD MONTGOMERY N. BETHESDA 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 5705 BALSAM GROVE COURT 20852 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12 Was Decedent Ever in LLS Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: WHITE If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE MANAGER FINANCIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DALINSKY NORINSKY CHARL OTTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE KELLNER/HUSBAND BALSAM GROVE COURT, N. RETHESDA Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM.PARK 12/13/2009 REISTERSTOWN, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 191 disease or condition Medical resulting in death) Due to (or as a pinsequencial of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 0 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnance in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 | No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) Dec タ スッチ 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Un F 5 Pending 1 Natural 2 Accident 5 81 f-17-5/10 tel DV41 1 Tes 2 No Dec Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined IN DONE Bex 48690 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MI 0057268 autos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20814 8600 Old Georgetown Rd. Bethesda, Md. Nancy P. Lawless 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ RAY 10:26 AM No combos 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Battimore Baltimore Hospita ti 8. Date of Birth (Month, Day, Yea If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 FLORIDA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampiniup or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Kes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 STATES INITED 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 1 Specify: 3 Midowed 4 ☐ Divorced BLACK Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College_(1-4 or 5+) GOVERNMENT SPECIALIST EMPLOYMENT Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANDALISTOWN, MD 21133 ROBIN STEWARL DaughtER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 19/09 PIKESVILLE, MD RIDGE MILLER'S METROPOLITAN re of Funeral Service Lic 22. Name and Address of Facility Signa BROADWAY BALTO, MD 2,213 1639 N. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to or as a consequence of): Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearlh.

To the Funeral Director After this certificate has been signed by the attending physician and not here are linector after this certificate has been signed by the attending physician and completed lilectin by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Heast 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number KES 13, 000 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Physician/ Ruby Lee Warner 4:00 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MUSPITAL OF BALTIMORE ALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** November 8, Months Hours ***1945 Mary Land **Director** Usual Residence of Decedent show 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21215 4601 Pall Mall Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any injury or other traumatic event at any injury or other event at any injury or other traumatic event at any injury or other traumatic event at any injury or other event at any injury or other traumatic event at any injury or other even (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Oscar Stinnette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 East Jeffrey St. Baltimore, Maryland 21225 Mike Warner 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 🛛 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Dec. 12, 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician. day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure, status epilepticus, deep page 2 should be Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? vein thrombosis, coronary artery disease 24a. Was an has autopsy performed' certificate 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 🔀 No 1 📈 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

30. Name and address

31. Date filed (Month, Day, Year)

DEC 16 2009

MOSPITAL OF BACTIMORE, 2401 W-BELVEDERE AVE, BACTIMORE, MO21215

person who completed cause of death (Item 23a) (Type, Print)

SINAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day keember 12 MAPP:00 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 1 🗌 M 400.25.9334 42 JAN 13, 1967 ΚY Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No PA **HARRISBURG** Dauphin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 4012 THICKET LN. 17110 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 🗓 X\o WHITE Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self Employed Pest Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jim Glass Joan DuPuy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROGER WOODYARD HUSBAND 4012 THICKET LN HARRISBURG, PA 17110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XX Burial 2 ☐ Cremation 3XX Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest/Lawn Cemetery Dec 16, 2009 Erlanger, KY 21. Signature of Funeral Service Licenson
GRECORY FINA
23a. Part I. Enter the disease, or complice shock, or heart failure. List only one 22. Name and Address of Facility FINK FUNERAL HOME, P.A. t/a MARYLAND MO 426 CRAIN HWY SW GLEN BURNIE, MD 21061 t/a MARYLAND MORTUARY SUPPORT M01148 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- " any injury or other traumatic event." **Physician** /Medical **Examiner** ician and burial-transit The law requires that the death certificate be executed

as the t use

signed by the att

certificate

filled in by the funeral director,

completely

31. Date filed (Month, Day, Year) DEC 16 2009

TIMOTHY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

Division of Vital Records, P.O. Box 68760,

Immediat Cause (Final disease or ndition resulting in eath)		e Shock		Oriset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Fundal Infection  Due to last a consequence of:  Due to last a consequence of:  C. Multiple Myelom			
resulting in death) Last	Due to (of as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		ctopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the und	erlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
	· · ·		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?			h (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Copatient 2 ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
27. Manner of D th 1 Natural 5 ☐ Pending 2 1 Accident investigation		28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred
3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Street City or Town, State	and Number or Rural Route Number, te)
	nysician: To the best of my knowledge, death or niner: On the basis of examination and/or inves and manner stated.			
29b. Signature and title of certifier	Human	29c. License number	7	Pate signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 30 per dyr g898 12-16-09 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year 1039 Yakubov evda 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner i Randallstown MD Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **№** M 2 🗆 F Months Days 83 **Director** 218-33-6891 03/16/1926 BAKU Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 □ Yes 2**y**□ No MD BALTIMORE BALTIMORE 10e, Street and Number 10g. Citizen of What Country? 2 RUSSERN COURT. Funeral 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Ye's or No-If Ye's, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ir than " Elementary/Secondary (0-12) College (1-4or 5+) MANAGER ELECTRICAL CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental I tem 27 is marked of other traumatic eve ISAAK YAKUBOV ပ္ LIA YUSOPHOVA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARRA YAKUBOVA/WIFE If item 27 or other t RUSSERN COURT, #1A , BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE HEBREW 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Li 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ∐Yes 2 X No 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed caus e of death (Item 23a) (Type, Print) Northwest Hospital Randallstown, Md. Everette D. LaFon Jr. 21133 31. Date filed (Month, Day, Year) 32. Ogistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH C898 12/16/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER **ZASLOW** 2009 12:25A ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 APPLE GROVE ROAD SILVER SPRING MONTGOMERY 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth . Age (In yrs. last birthday) Funeral 1 □ M 2 💢 F Hours 12-16-1921 185-12-1969 87 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If fieler 27, is marked et than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No SILVER SPRING Gaithersburg MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20878 311 HIGH GABLES DRIVE, #203 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. ≥ 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ **MEYER** HOFFMAN MARY GOLDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA KUPPERMAN / DAUGHTER 311 HIGH GABLES DR., #203, GAITHERSBUR<u>G, MD 20878</u> 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 12/15/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CORONARY HEART DISEASE Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSIVE HEART DISEASE Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to tor as a consequence on CANCER OF BREAST attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical PERIPHERAL VASCULAR DISEASE Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires t DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director, After this certificate has been siy completed filled in by the funeral director, page 2 should to mapleted filled in by the funeral director, page 2 should to 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, ြု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year, UMINOC Moinin D0047330 12/14/2009

State

Registrar

50 W. EDMONSTON DR., SUITE 207, ROCKVILLE, MD. 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS V. JOSEPH

6

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 145 PM L. HNDERSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 397-34-3714 1 M 2 □ F Months Hours 0972371939 Wisconsin 70 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 ☐ Yes 2 ☐ No Crownsville 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2000 Martins Grant Court 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1√1Yes 2 ☐ If Yes, Give Year or Dates: ^{2□No} 61-64 1 Never Married 2 Married 1 □Yes 2 No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Agent FBI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertram Edison Anderson Jane Delfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan F. Anderson Spouse 2000 Martins Grant Court Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/30/2009 Crownsville,MD 21. Signature of Funeral Service License 22. Name and Address of Facility 851 Annapolis Road Gambrills MD 21054 Hardesty Funeral Home P.A. Dales 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lyear Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

**Examiner** sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed I I be det page 2 should has certificate director, After this

**Funeral** 

**Director** 

28a-f show

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23a

items

'natural", or

i Hygiene. other than "

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Iraal once.

**Physician** 

/Medical

event, the Medical Examinar must be notified at

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

ospital or Attending Physician: The law requires that the death certificate be executed hours after death. filled in by the

in 24 in 24 he F	one) and manner stated	d.	time, date and place, and due to the dadacts)
	29b. Signature and title of ceptifier	29c. License number	29d. Date signed (Month, Day, Year)
F > F 0	Susen H. Kreeged, Mis	D44838	11/21/09
0 1 0 1	30. Name and address of person who completed cause of deat	h (Item 23a) (Type, Print)	1 1100
31104	SUSAN H. KRIEGER, M	D 445 Detense Hwy.	Annap. MD 21401
State	e 31. Date filed (Month, Day, Year) 32. Registrar's		/
Registra	NOV 2 4 2009 Lener	a B. parker	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Location (Street and Number or Rural Route Number, City or Town, State)

and place, and due to the cause(s) Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician Month Year NOVEMBER 2009 1:53 PM HELEN THERESA ANDERSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner CENTREVILLE** QUEEN ANNE'S CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Yrs. 021-20-0017 MASSACHUSETTS Director 82 DEC.5, 1926 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f shovine Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director QUEEN ANNE'S CENTREVILLE MT) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 CLAIBORNE FIELDS DRIVE 21617 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygies Important: If Item 27 is marked other tt any injury or other traumatic event, this once. 12 -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DENNIS McLAUGHLIN MARGARET McGONAGAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 116 CLAIBORNE FIELDS DRIVE, CENTREVILLE, MD 21617 PATRICIA DEMERS/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PETER'S CEMETERY 11-9-2009 QUEENSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** typotension Laus /Medical Due to (or as a consequence of) Examiner Friel bleeding days Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 3 kesmos domentia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2□ No 1☐ Yes 2 X No 1 Tes To the Hospital or Attending Physicien: : After this certifice funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? 1 Natural 5 ☐ Pending deeth. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deet To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier with my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lane, Easton, MD MD Crowley, MD 610 32. Registrar's Signature State Registrar

			For State	State of M	laryland / De	partment of	Health a	and Mental H	vaiene	
	Physicia Medic		Registrar  1. Decedent's Name (First, Middle  JOSEPH FRANK		C	ertificate of	Death	2. Date of D Month <b>NOVEM</b>	eath	3. Time of Death 2009 2:00 P M
	Examin		4a. Facility Name (if not institution) 7127 FIRST A	•		4b. City, Town,	or Location o	of Death	4c. County	of Death
	Funeral Director		5. Social Security Number 216-05-2111	6. Sex 1 <b>X</b> M 2 $\square$ F	ge (In yrs. last birthday 92 Yrs.	) If Under 1 Year Months Days				9. Birthplace (State or Foreign MARYLAND
	aryland a-f show ified at	ector	Usual Residence of Decedent  10a, State 10b, County  MARYLAND QUEE	EN ANNE'S	10c. City, Town or					10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
	with the M 23a or 28 1st be not	Funeral Director	10e. Street and Number 7127 FIRST AV			10f. Zip Code <b>216</b> 5	i8		10g. Citizen of UNITE	
9800	e filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🗶 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 K	Ever in U.S. 13	. Was Decedent of	Hispanic Oriç ban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	)- 14. Rac	e - American Indian, ck, White, etc.
Maryland 21215-0036	vithin 72 hou jiene. <b>er than "nat</b> <b>the Medi</b> ca	Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12) 12	nt's Education est grade completed) College (1-4 or	5+) (Giv	edent's Usual Occu e kind of work done DO NOT use retired FICE MANA	during most ()	of working	16b. Kind of B	usiness Industry
yland ;	should be filed vand Mental Hygis marked otheraumatic event,	To Be	17. Father's Name (First, Middle, L				1	er's Name (First, Middle	e, Maiden Surnam	e)
	and 2 should be Health and Mentr tem 27 is marked ther traumatic e		19a. Informant's Name/Relationsh					r or Rural Route Numb		
Baltimore,	Page 1 nent of ant: If ii ary or o		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 4 🗋 Donation 5 🗆 Other (S	3 ☐ Removal from State	20b Place of Dis Sidmeted/ E CATHOL	position (Name of antakry <b>5</b> other pla IC CEMETE	nce)	DEC. 4 2009		City or Town, State
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service L	Helbertle	n	FEELOWS ddr 408 SOUTH	HELFEN LIBER	NBEIN & NEW	NAM FUNI	ERAL HOME, P.A. VILLE, MD 21617
	nysician Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	anly one cause on each line	d the death. Do not ele.			cardiac or respiratory a		Approximate Interval Between Onset and Death
	be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	с	a consequence of):					
. Box 68760	To the Hospital or Attending Physician: The law requires that the death cartificate be exwithin 24 hours after death cartificate be exwithin 24 hours after dectore: After this certificate has been signed by the attending physician To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal death 3	☐ Ectopic pregnar	псу		23d. Da	te of delivery inth Day Year
ls, P.O.	uires that t n signed b lid be detα	by	Part II. Other significant condition	sus Anes	ula			1		ribute to the cause of death?  3  Probably 4 Unknown
Record	he law requite has beer page 2 shou	Completed	CEREBEC	VASCULA	2 INGL	IFFEE	ENG	perf	opsy formed?	Were autopsy findings available prior to completion of cause of death?
<u></u>	an: T tifica tor, p	Be C	25. Was case referred to medical			26. F	lace of Deat	h (Check only one)	Z <b>eza</b> NO	1 L 165 2 M 140
Ζţ	ysici s cer direc:	To B	examiner? 1  Yes 2  No	Hospital:	ient 2 🗆 ER/Outpat	LOH	ner:	rsing Home 5 🖺 Res	idonas e 🗆 Out	or (Cancifu)
Division of Vital Records,	tending Phy leath. :or: After thi the funeral of	Certificate: T	27. Manner of Death  1   Natural 5 □ Pendin 2 □ Accident Investig 3 □ Suicide 6 □ Could	28a. Date of inj 9 pation	ury 28b. Time ay, Year) injury	of 28c. Inju wor M 1	ry at	28d. Describe	how injury occurre	
DIVIS	ital or Att urs after d ral Direct led in by 1		4 Homicide determi	ined 28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office			(Street and Numbe wn, State)	er or Rural Route Number,
	the Hosp nin 24 hou the Funer apleted fil.	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best or xaminer: On the basis of Nurse Practioner: To the	examination and/or inve	estigation, in my opin	ion, death occ	curred at the time, date	and place and due	e to the cause(s) and manner states
	vitt Con		29b. Signature and title of certifier	1 - 1		29c. Licens	se number	_	29d. Date signed	(Month, Day, Year)

30. Name and address of person who completed cause of death (Rem 23a) (Type, Print) ERIC F. CIGANEK, M.D. 629 RAILROAD AVE., CENTREVILLE, MD 21617 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 09 Physician/ Month Day 25 8:05 P M Samuel Bell Jr. 11 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Queen Anne's 416 Quarter Creek Drive Queenstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25 9. Birthplace (State or Foreign Country) **Pennsylvania** 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Day, Y 1 🕱 M 2 🗆 F Months Director 155-22-0483 85 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director MD Queen Anne's Queenstown 1 Yes 2 X No 10e Street and Number 6 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 416 Quarter Creek Drive 21658 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò ρ 1 Never Married 2 X Married If Yes, Give Year or Dates 1943-1945 1 Yes 2 X No Specify: 'natural", Specify: Completed 3 Divorced 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other ti 12 Advertising Agency Owner Advertising Agency Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Bell Isabel Frazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Quarter Creek Drive, Queenstown, MD 21658 Anne Bell/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 🗷 Cremation 3 🗆 Removal from State Chesapeake Cremation 11-27-2009 Stevensville, MD 4 Donation 5 Other (Specify) al Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death the g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the onderlying cause given in Fart I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be director 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: After management of the function of the func 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying 綱 e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month Day

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. **Physician** Bucci 2009 2:35A 27, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Bradford Oaks Nursing Home Prince George's Clinton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M XXF 1909 Director 578-36-5414 100 Nov. 6. Washington, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f sk other traumatic event, its Medical Expriner must be notified Director Maryland Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 U.S.A 12407 Appleby Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2**X**No Specify: White Specify: <u>ک</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other trainmatin. Elementary/Secondary (0-12) College (1-4or 5+) 8 Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raffaele Presutti Sante Santilli 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12407 Appleby Ct. Upper Marlboro, MD 20772 Helen Codori (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/5/2009 | Clinton, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi Exami and Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy ρ Month Year 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 Arsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 5 ☐ Pending investigation 1 🗆 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier ical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie dress of perso who completed cause of death (Item 23a) (Type, Print) 30. Name and a MD 11701 Livingston Rd. #103 Ft. Washington, Md. 20744 Frank Ryan. 31. Date filed (Mor 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State 11/24/09 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Inomas Medical 7:45 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. 171671954 Director 220-60-8498 North Carolina Usual Residence of Decedent or 28a-f show e notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Anne Arundel Annapolis 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21409 959 Aqua Court USA items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc." P Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) IT Specialist GAO 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dawn McNeil Ralph Cecil Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 959 Aqua Court, Annapolis, MD 21409 Serena Boyd - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/25/2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jeune adame concer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 9 Unknown the detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be The law requires 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 🗌 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 \( \text{Yes} မ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Escritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifie 29c. License number DUD64379 2039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Take Rd Sule 300 Anna am alla 31. Date filed (Month, Day, Year) State NOV 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PAULINE KAY BROWN 2009 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Hours Min. Nov. 3 Pay, Year) 57 1 □ M 2 √2 F MaryTand 52 212-68-7975 Director Usual Residence of Decedent shov 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11029 Powell Road 21788 U.S.A. and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o John Robert Bowers Dorothy Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Brown, Jr. 11029 Powell Road, Thurmont, Maryland 21788 / Husband permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t injury or other 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Blue Ridge Cemetery 11/23/09 Thurmont, Maryland 4 Donation 5 Other (Specify) 21. Sonature of ROBERT E. DAILEY & SON FUNERAL HOMES, EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hypertensin disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and abe detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗆 Yes 2 🗷 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

only one) 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

well

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

LINDA CRUM MUEHL CRUP

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1564 Opossumtown Pike, Frederick, MD 21702

29d. Date signed (Month, Day, Year)

29c. License number

P069310

3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

arke

		For State Registrar		State of	Marylan		artment of I r <i>tificate of</i>		Mental Hy		2009	40145
Dhusisi		1. Decedent's Name	e (First, Middle, La	st)			•		2. Date of D Month	eath Day	y Year	3. Time of Death
Physici /Medic		Ro	salee T.	Cogswel	1				Nov.			11:45A M
Examin		4a. Facility Name (If not institution, give street and number)						r Location of Dea	County of Dea	ath		
		16717 Frederick Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					Mount A	9			Howa	
uneral			- 1	Sex 7. □M.21√2 F			If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, E	Pav. Year)	C	rthplace (State or Foreign country)
irector		212-32-5	9469	- X	77	Yrs.			Sept.	8, 1	932 V:	irginia
A		Usual Residence of 10a, State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
fsho	ō	Maryland	Howard			Ma	unt Airy					1 □Yes 2 No
28a-	Director	10e. Street and Nur				HO	10f. Zip Code			10g. Cit	izen of What C	ountry?
3a or		16717 F	rederick	Road			2177	1			TT C A	
ms 2	Funeral	11. Marital Status	rederiek	12. Was Decede			Was Decedent of I	Hispanic Origin? (	Specify Yes or N		U.S.A. 14. Race - Am	erican Indian,
or ite			ed 2 Married	Armed Force	<b>X</b> No			an, Mexican, Puer	rto Rican, etc.)		Black, Whi	te, etc.
Four Exert	l by	3  ▼ Widowed	4 Divorced	If Yes, Give Year or Date			1 □ Yes 2X□ No	Specify:			Specify: V	Vhite
natu	Completed	(Spec	15. Decedent's Ed	ducation			dent's Usual Occu-	pation during most of we	orkina	16b. Ki	ind of Business	s/Industry
an "	ם	Elementary/Secon		College (1-4	or 5+)	life. I	DO NOT use retire	d)	9		<b>.</b>	
rer th	S			2		N	urse	I	4001 . 4414.11			re Provider
dott	Be	17. Father's Name (	(First, Middle, Last,	)				l .	me (First, Middle		Surname)	
narke	우		er Coff			1		Ann				
raun		19a. Informant's Na	ame/Relationship (	Type. Print)				and Number or R				
m 2 ther		Linda A.  20a. Method of Disp		t - Daug			Geaslin	Drive, N	Middletc Date		Marylar ocation - City o	
er it			Osition ☐ Cremation 3 ☐	Removal from Sta	ate C	emetery, cren	natory or other pla	· !				•
rtant			5 ☐ Other (Specif		Tr			tery 11/2			bon, Ma	
Department or research and wenter hyperical property of items 23a or 28a-f show more any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Fu	_ 7	Lill Will	liam	$ \mathbf{A} \mid \mathbf{M} \\ \mathbf{M} $	oleswort 6401 Rids	ess of Facility n-Willian ge Road,	ns P.A.,	Fund	eral Ho	ome od 20872
rsician ledical aminer												Approximate Interval Between Onset and Death
physician and s the burial-transit	edical Examiner											
To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Mec	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	Ectopic pregnand Other <i>(specify)</i>				23d. Date of de Month	Day Year				
signed I be de	þ	Part II. Other signif	icant conditions of	*	h but not resu	ulting in the ur	nderlying cause giv	ven in Part I.			use contribute ☐ No 3 ☐ F	to the cause of death?  Probably 4 Unknown
cate has been page 2 shoul	Completed								24a. Wa auto per 1 □ Yes	s an opsy formed? 2 🖾 No	prior to	autopsy findings available completion of cause of
sertifi ector,	Be	25. Was case referr examiner?	red to medical	Manit-1					ath (Check only	one)		
this cal dire	မ	1  Yes 2				ER/Outpatier		4 Li Nursing I	Home 5 ₹ Res			ecify)
: After e funera	tion:	27. Manner of Death  1 Natural  2 Accident	n 5 ☐ Pending investigation		Injury Day, Year)	28b. Time of Injury	Wor	ryat rk? ]Yes 2 □ No	28d. Describe	how injur	y occurred	
al Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace of	Injury - At ho , etc. (Specify	ome, farm, stro	eet, factory, office			(Street an wn, State		Rural Route Number,
ne Funera pletely fills	Medical (	29a. Certifier (Check only one)	1⊠ Certifying Ph 2□ Medical Exam		is of examina							
<b>70</b> moo	Ź	29b. Signature and	title of certifier	Mm	CRI	R	29c. Licens	1027			te signed <i>(Mor</i> vember	23, 2009
3		30. Name and addre		-	of death (Item	P 40.5	Print) Suite	104 N	H. Arry	M		2177/
Sta Registra		31. Date filed (Mont	h, Day, Year)		istrar' Signa	ture	park	1		)	3,,,,,	

DHMH 17 Rev 1/2001

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			. For	State of Maryland	/ Depa	artment of	Health and N	•	_	40146
			1 - State Registrar		Cer	tificate of	Death		). No.	70110
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  DOROTITY	JUNES C	ARLI.	SLE		2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death		4c. County of Dea	th
			Coffman Nursing Ho	me			erstown	,	Washingt	
	Funeral Director		220-09-2856	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry) sachusetts
3-UUS0 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: filtern 23a or 28a-1 show important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show any njury or other traumatic event. It a Modeal Examiner must be inclifted at once.	_	Usual Residence of Decedent  10a. State  10b. County	10c. City, 7	Fown or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No
Ma Ma	8a-( a	Funeral Director	Maryland Washingto	n Wil	liams				0	
ith t	or 2	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Ci	ountry ?
ath v	s 238	rai	16505 Virginia Ave	. # A316 12. Was Decedent Ever in U.S.	12.1	21795	Hispanio Origin? (Sr	pecify Yes or No-	U.S.A.	encan Indian
er de	ma l	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13.1	f Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Black, Whi	
OCCO hours aft	o' a	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: Wh:	ite
<b>5</b> 2	ature Cal E		15. Decedent's Edu		16a. Deced	dent's Usual Occu	ipation		6b. Kind of Business	
ייי איני איני	2 7	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	DO NOT use retir	during most of wor ed)	king		
N N	or the	Completed	Cionionary/oscordary (o 12)	2		Legal Se	ecretary		Govern	ment
ָם, פּוֹּ	othe vent.	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
y iand	Mental urked o	10	Benjamin Rowe						e Andrew	
Mary 42 sho	and Is me		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stree	at and Number or Ru	ral Route Number, (	City or Town, State,	Zip Code)
, M	n 27 n 27 er tr		Mark Carlisle / G						cus, MD 2	
ore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	ce of Dispo netery, crer	sition (Name of matory or other pl	асе)	Date 20	0c. Location - City or	Town, State
Saltimor	ant: I		`4 ☐ Donation 5 ☐ Other (Specify)	Smit			tory 12/4		mithsburg	
	Depart Import any nj		21. Signature of Funeral Service Licens	9					Funeral C	
D a	10 5 5 3		4							aryland 2174
			23a. Part . Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. ne cause on each line.	Do not ent	er the mode of dy	ring, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
P	hysician		Immediate Cause (Final disease or condition	METASTAT						MONTH
	Medical		resulting in death)	Due to (or as a conseque	nce of):					
-	xaminer		Sequentially list conditions,	. BRIENST		CER				MONTHS
Ģ	=	Examiner	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	noe of):					Monelis.
<b>5U,</b> be executed	sician and e burial-transit	tam	that initiated events resulting in death) Last	c. CACITEXI	A solve					morally,
oc,	cian ourial	ai E		Due to (or as a consequen	1100 01).					
	physic the t			d						
-	attending phys	Physician/Medic	IF FEMALE:	23c. If yes, outcome of pregnanc	34				23d. Date of de	Nivon
HOX HE	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea	eath 3[	☐Ectopic pregnan☐ Other (specify)	су		Month Month	Day Year
9		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	5	_ Other (specify)				
7 2	been signed by the should be detached		Part II. Other significant conditions co.	ntributing to death but not result	ing in the u	inderlying cause o	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
dS,	sign ed b	d by						1 ☐ Yes	s 2□No 3□F	robably 4 DUnknown
ecords,	need	Completed						24a. Was an	24h Were a	tutopsy findings available
Hec	cate has page 2 s	Idm						autopsy	prior to	completion of cause of
	(G CT								No 1 Ye	s 2019No
VItal	certificate rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			When the	th (Check only one		
öå	this al du	-T	1 ☐ Yes 2 🕅 No	1 inpatient 2 i Ei	H/Outpatie 8b. Time o	nt 3 DOA	4 Ninursing F	28d. Describe how	nce 6 Other (Sp winjury occurred	ecity)
ב ב	h. After funera	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	W	ork? □Yes 2□No			
ISIC	deatl ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, st				eet and Number or F	Rural Route Number,
DIVISION	after Dire	Certification:	4 Homicide	building, etc. (Specify)				City or Town,	State)	
DIVISION OF VITA	within 24 hours after death.  To the Funeral Director: A completely filled in by the ft	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowl iner: On the basis of examinatio and manner stated.	ledge, deat on and/or in	th occurred at the evestigation, in my	time, date and place opinion, death occu	e, and due to the car arred at the time, da	use(s) and manner ate and place, and du	as stated. ue to the cause(s)
off o	o the	Me	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Mor	oth, Day, Year)
Ĥ	გ ⊸ გ		No.	i mo		1	14171		Der 172	2009
			30. Name and address of person who co		23a) (Tyne	Print)	70301		74000	10001.
34	1-4			1190 H90	111 -	^	ROM	HITAEVA	nown M	1) 2(740.
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu						
	Regist		DEC 16 A 94	100	h .	Kand I				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day DEC. **Physician** 20**′**6°9 03 5:20 AM William Norman Cephas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Federalsburg 401 Porter Court Caroline 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20,1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**∑** M 2□ F 76 218-24-5501 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location Federalsburg MD Caroline Director 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21632 401 Porter Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tayes 2 No
If Yes, Give
Year or Dates: 153-55 1 Never Married 2K Married Black 1 ☐ Yes 2 ☑ No Specify: Specify: <u></u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B & O Railway Railroad Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iola M. Cephas Cannon Emerson Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 Porter Court, Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type. Print) Hattie R. Cephas/Spouse 20b. Place of Disposition (Name of Cametern Commatory of Other place)
Eastern Sn. Veterans 20c. Location - City or Town, State Hurlock, Maryland 20a. Method of Disposition 12/10/09 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Mil 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** avears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to or as a consequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 Other (specify) □IJnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 27 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physlcian: The law requires that the death certificate be executed and burial-trar physician s the burial Division of Vital Records, P.O. Box 68760 attending pl ed by the a signed I ficate has been sing. certificate After this certification funeral director, p death. within 24 hours after death

To the Funeral Director;
completely filled in by the

Certification: To

s 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Example men

Baltimore, Maryland 21215-0036

1 Natural 2 ☐ Accident 5 Pending investigation 3 Suicide

4 ☐ Homicide

(Check only

29a. Certifier

Could not be determined

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

DR. DAVID SMITH

29b. Signati and title of cartifier

License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEAL DRIVE EASTON MD 211

31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar

Medical

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10c.perFH, G898, 12/16/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Brvan Keith Dunham 2009 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel **Examiner** Baltimore Washington Med Ctr Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Days 212-84-0477 0872974962 Director 47 PA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pasadena MD Anne Arundel Pasade3 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 21122 10g. Citizen of What Country? "natural", or items 23a or Funeral 210 List Ave USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Carol Jean Steiner မ Herbert Gene Dunham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8454 Geneva Road, Pasadena, MD 21122 John Irwin / Brother 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date W/ Arundel Crematory 12/05/2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home 21. Signature of Funeral Service Licensee M01452 and Cremation Center, PA 2601 Mountain Road, Pasadena White 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between astatic Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Physician/Medical Examiner Que to (or as a nonsequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manny of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type Print) 301 WUSP HAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

なく

Dunham

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Wilma J. Fish /Medical 11/17/2009 11:48pm 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kris Leigh Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/21/1923 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 3 TYF Director 379-16-9277 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 te marked other then "neturel", or Items 23a or 28a-f show other treumatic event. The Mudical Example must be notified at MD 1 ☐ Yes 3√1 No Director Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7510 Crofton Colony Dr. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KMes 2 □ No WWI 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Item eny injury or other treumatic event, the Medical Examinar once. 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmaceutical Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo J. Stevens ٥ Dorothy Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7510 Crofton Colopy Dr. Crofton, MD 21114
ce of Disposition (Name of Date 20c. Location - City or Town, State Steven E. Fish Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/21/2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Date 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the digrase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence To the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ծ Completed 1 🗌 Yes 2 🗆 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificete has autopsy perforn SSION 1 Yes 2 DN : After this certifical funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Nomer (Specify) Certification: To 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours To the Funeral Territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and le of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) IGITAL DR. 31. Date filed (Month, Day, Year) 32. Re State 2009 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death <del>2009</del> 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 7. Physician/ 5:50 a M Mary Esther Foster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Chestertown Heron Point If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours 1 M 2 X F JAN. 8 1918 MARYLAND 91 **Director** 217-03-5808 Usual Residence of Decedent or 28a-f show notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. That: If I few 27 is marked other than "natural", or items 23a or 28a-f sho into rother traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHESTERTOWN 1X Yes 2 No KENT MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21620 2006 HERON POINT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 **K** No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PHARMACEUTICAL BOOKKEEPER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARY ESTHER TINLEY MAURICE ELMER WILCOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 SENECA SHORE ROAD, PERRYVILLE, MD 21903 GARY P. FOSTER/SON Baltimore, 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of OL Den Wir Ecra PANGLOS Mer place) NOV .Dat 10 1 X Burial 2 Cremation 3 Removal from State WYE MILLS, MD **CEMETERY** 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of uneral Service Licensee FENTOWS Addrest FENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications to at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one causi Immediate Cause (Final Ph_sician/ My De disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 1 ☐ res ∠ ☐ 9 ☐ Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has performed? Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After work? Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month GOOD HAND 8.25PM WILLIAM 30 2009 NISV 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMME SUMMIT PARK RETHAR CATONS VILLE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Year)
OCTOBER 28, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 X M 2 □ F 81 212-26-1087 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State 1 ☐ Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? UNITED STATES 97 ANNAPOLIS VIEW ROAD 21666 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SUPERVISOR FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTHA ELLEN TYSON JAMES B. GOODHAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 HIGHFIELDS DRIVE, CATONSVILLE, MARYLAND 21228 WILLIAM T. GOODHAND, JR/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE
CREMATION CENTER 20c. Location - City or Town, State 20a. Method of Disposition DECEMBER 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 5 ☐ Other (Specify) 2009 4 ☐ Donation 21. Sign re Funera Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DEMENTIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): SENILIT Sequentially list conditions, it is a sequentially list conditions, it is a sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No NA 1 □Yes 2.□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

P.O. Box 68760 Records, **Division of Vital** death.

sician and burial-transit the attending physician ned for use as the burial signed by t icate has been siç , page 2 should b Completed certificate has director, Certification: To After this funeral c Attending the ō

**Physician** 

Examiner

**Funeral** 

Director

show

Director

Funeral

Completed

Be

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Examiner

Physician/Medical

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Be

Medical

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Examinar must be notified at

death v

72 hours after

should be faund Mental

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is no any injury or other traur

**Physician** 

/Medical

Examiner

Maryland 21215-0036

imore,

/Medical

24 hours after deatl Funeral Director: completely within 2

and manner stated. 29b. Signature and title of certifier

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PLACE SUITE 34 AATEM ME MO 21601

ATTENDINE

05056948

NOV 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 MES UMNINDA Arrow 7

31. Date filed (Month, Day, Year) 2009

6 Could not be determined

32. Pegistrar's Signature backer

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per phys. G900 2/19/10 dk
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month s. Linda Gaglione 11:21 A M Nov 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Date of bill. (Month, Day, Ye. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours ,1949 New York 123-40-3912 60 Director Feb. Usual Residence of Decedent shov 10a. State 10c. City, Town or Location death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director MD Anne Arundel Arnold 1 🗆 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Elmwood Court 21012 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumastic. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Mackenzie Marie Monte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony M. Gaglione / Husband 403 Elmwood Court Arnold, MD 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, I Dat 01 20a. Method of Disposition Dec 2009 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 5 Euneral Service License Barranco & Sons, P.A. Severna Park Funeral He 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician ocardial disease or condition Medical resulting in death) Due to (or as a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate bauce. Enter or denying Cause (Disease or linjury Due to (or as a consequence of) Exam sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Medical The law requires that the death certificate be Box 68760 as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? 5 Other (specify) 1 Yes 2 No Pregnant at time of death the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 🗌 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No within 24 hours after ucau..

To the Funeral Director: After this c ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title-of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Examiner Prince Ge<u>orges</u> Southern Maryland Hospital Clinton f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Yrs. September 29, 1921 Michigan 298-14-1443 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Exanter in ust be notified as Director Maryland Charles White Plains 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4225 Southwinds Pl. Apt#221 Funeral 20695 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces:

1 NYes 2 No
If Yes, Give
Year or Dates: 1943-1973 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ş 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Violinist U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonie Schmelar ဂ Phillip Horak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4225 Southwinds Pl. Apt#221, White Plains, MD 20695 <u>Bertha Horak</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory Nov. 26,2009Glen Bernie, Maryland 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of):

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Robert Horak

Physician

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

4b. City, Town, or Location of Death

2. Date of Death

November

23,

USA

2009

Race - American Indian, Black, White, etc.

Specify: White

23d. Date of delivery

OUD LINE CENTER WALTENFIND ZEEDZ

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 為☐ No

10:15 P^M

P.O. Box 68760. Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A

Physician/Medical

à

Completed

Be (

Certification: To

Medical

29b. Signature and title of certifier

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? res No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

	9295 io Hans-Gei	harc			n Black Indel and / Departm							09 4015	
			1- For State Registrar		Certific	ate of	Death				ı. No.		
Mar	Physici dical Exami		Decedent's Name (First, Mide						1	2. Date of Death Month November	Day Year	3. Time of Death 0915 hrs	
Mec	ilcai Exami	iici	Heino Hans Ge 4a. Facility Name (if not instituti	erhart Hopp ution, give street and number) 4b. City, Town, or Loc					on of Death	November	4c. County of D		
•			7310 Edgewood Roa			Annapolis			Anne Arundel		del		
	Funeral Director		5. Social Security Number UNK	6. Sex	7. Age (In yrs. last bir	thday)	If Under 1 Months		Jnder 24Hrs.	1	F	. Birthplace (State or oreign	
	Difector			1 X M 2 F	62	Yrs				4/19/1	947	Country) Germany	
	any		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Town	or Locat	ion				10d. Inside City Limits		
Ĩ	nd show nce.	اۃ	MD Anne	Arunde1		Anna	apolis					1 Yes 2XX No	
)	Maryla 28a-f d at o	Director	10e. Street and Number		•		10f. Zip Co			10	0g. Citizen of What Country?		
	r death with the Maryland or items 23a or 28a-f show must be notified at once,		7310 Edgewood				i	2140			USA		
	ith wit tems?	uneral	11. Marital Status  Never Married 2	12. Was Dec					Origin? ( Spe ican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
	ter des ", or i	╙		1 Yes	2XX No	1 Yes 2 X No specify:					Specify:	White	
	ours af atural camin	d by	15. Decedent's Education (Sp	or Dates: ecify only highest grad	de completed) 16a.				Give kind of wo		16b. Kind of Busin	ess/Industry	
	6 172 ho an "ns ical Ex	ete	Elementary/Secondary (0-12		. '	-			NOT use retire	;a}	Naut:	t 1	
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle	e Last)	+	'	Crafts		ther's Name	First Middle M	aiden Surname)	Icar	
	215- e filed tal Hy ked ot nt, th	Be C	,	Hans Heinrich Richard Hopp						Bisch			
	213 ould b d Men s marl	70 E	19a. Informant's Name/Relation		1		- ,				per, City or Town,		
	MD dd 2 sho llth and m 27 is		Meighen Hopp	Daught								ario NOP2LO	
	ore, es l ar of Hea If iter		20a. Method of Disposition  1 Burial 2 X Crematic	on 3 Removal fr	l		sition (Name o her place)	of cemetery	۷,	Date	20c. Location - Ci	ty or Town, State	
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other		Atla:	ntic	Crema	tory	12/	4/2009	Glen Bur	nie, MD	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee							uneral Ho s, MD 21	ome, P.A.	
	Physician		23a. Part I. Enter the disease, of		aused the death. Do r	ot enter t	he mode of d	ying, such	as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval	
	/Medical xaminer	9	failure. List orly one caus		ng complic	atin	g hypo	therm	nia			Between Onset and Death	
١.	xammer		or condition resulting in death)  Due to (or as a consequence of):										
		ē	Sequentially list conditions, if any, leading to immediate		a consequence of):								
		Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	C	a consequence of):								
	uted nd ransit		events resulting in death) Last	d.	consequence or,								
	Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	dical	X UNPENDED	AMENDED	3a,27,28a-	·f.ne	rME. 9	898 1	12/21/0	)9 TT			
	Box 68760, e death certificate but the attending physic ed for use as the but	cian/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes,	outcome of pregnancy						23d. Date of de		
	K 68 1 certif ending use as	cian	past 12 months?	I I Live I		_	etal death ther <i>(Specify</i>	_	ctopic pregnar	icy	Month	Day Year	
	BO) e deatl the att	hysi	1 Yes 2 No 9 U	a Olikii					W				
	P.O. es that the igned by be detach	by P	Part II. Other significant cond	litions contributing to	o death but not resulti	ng in the	underlying ca	iuse given i	in Part I.			Probably 4 Unknown	
	n of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be deta		-		-					24a. Was a		ere autopsy findings available	
	COr law re has be	ompleted								autop perfor	med? dea	or to completion of cause of ath?	
	Re I: The ifficate rr, pag	ပ	25. Was case referred to medic	ral I			26	Place of De	eath (Check o	1 Yes	2 No 1	Yes 2 No	
	of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	o Be	examiner?	Hoopital	Inpatient 2 ER/0	Dutpatien		Other	• -		Residence 6	Other: Scene	
	n of V ding Phy.	-	27. Manner of Death	28a. Date	of Injury 28b h, Day, Year)	. Time of		. Injury at V			now injury occurred		
	ttendi death.	atio		nding restigation Fd 1	1/30/09 Fd		9 am	Yes 2			t drowne		
	Division pital or Attendio ours after death. leral Director: Affiled in by the fü	ertification:	3 Suicide 6 Co	uld not be 28e. Plac	ce of Injury - At home, Creek	farm, stre	et, factory, of	ffice buildin	ng, etc.	28f. Location (S	tate)Back C1	or Rural Route Number, City reek Nature MD	
	E 8 5 E	ပ	29a. Certifier		st of my knowledge, de	eath occi	irred at the tir	ne, date an					
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Ex	caminer: On the basis and manner:	of examination and/or	investiga	ation, in my o	pinion, deal	th occurred a	the time, date	and place, and due	e to the cause(s)	
	To To	Me	29b. Signature and title of certi	fier			29c. L	icense nun	mber		29d. Date signed	(Month, Day, Year)	
			( 08 H A	e Aal	Vain	_		D.C.M.E.			December 1	, 2009	

CAO

State 31. Date filed (Month, Day, Year)
Registrar TEC 0 9 20

2. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 29, 2009 LOTTIE APPLE HASTINGS 5:35  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **EASTON** TALBOT WILLIAM HILL MANOR Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days NOV. 23 Hours ^{'ear)}1922 1 M 2 X F MARYLAND 87 Director 220-05-1961 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 💢 No OUEEN ANNE'S **QUEEN ANNE** MARYLAND 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 404 OWENS ROAD 21657 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc Yes 2 X No Yes, Give þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) 11 HOMEMAKER OWN HOME marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ige 1 and 2 should be filed nt of Health and Mental Hi t: If item 27 is marked oth JAMES APPLE LAURA WHEATLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE HASTINGS/BROTHER-IN-LAW 3822 WARWICK ROAD, EAST NEW MARKET, MD 21631 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1. Department of I Important: If it any injury or of EAST ONEW AMARKET Place) 1 🗶 Burial 2 🗌 Cremation 3 🔲 Removal from State EAST NEW MARKET, MD 4 Donation 5 Other (Specify) CEMETERY 2009 21. Signature of Fundal Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complicatio Approximate Interval Between shock, or heart failure. List only one cause SECONDS Immediate Cause (Final CARDIOPULMONARY ARREST Priysician/ disease or condition Medical resulting in death) Examiner CEREBROVASCULAR DISEASE WITH BRAIN STEM STROKE 48 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam OLD LEFT HEMIPLEGIA that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal dea 4 Pregnant at time of death Live Birth 2 Fetal death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 \( \sum \) Yes 2 \( \bar{X} \) No Month Day Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, cate has been sig page 2 should t Completed 24b. Were autopsy findings available 24a. Was an FAMILIAR TREMOR autopsy performed? Yes 2 No prior to completion of cause of After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 \( \text{Yes} \) မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No death 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

or Attending e Hospital or Attendi 24 hours after death e Funeral Director: A completed filled in by the To the Within 2

> 501 DUTCHMAN'S LANE, EASTON, MD 21601 WILLIAM H. WOOD, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

only one)

3 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

D08715

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

DECEMBER 1, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OVEN ber Mary G. Hopkins 30 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Easton jalboi entorial 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. (Month, Day, Country) Marvland 220-32-9535 73 Yrs **Director** ent Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location by Funeral Director 10d. Inside City Limits Caroline MD Preston 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22281 Hog Creek Road 21655 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married White If Yes, Give 1 ☐ Yes 2 ☐xNo Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Board of Education Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Assistant Caroline County Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pete Gannon Amelia Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane H. Towers/Daughter 4821 Smithville Rd., Federalsburg, MD 21632 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemetery 12/03/09 Preston, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DMONO Medical Examiner Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner as a consequence of the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ the funeral director, page 2 should be detached for in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 24 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 🗖 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and 1 ☐ Yes 2 ☐ No 3 € Probably 4 ☐ Unknown completed filled in by 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 29. 2009 Leroy Hammond November 7:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 24, 217-12-4146 87 1922 Director Oct. Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Caroline Greensboro 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Items 23a 406 N. Main Street 21639 U.S.A Completed by Funeral lited within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2X No If Yes, Give Year or Dates: to 1946 Specify: Specify: 3 Widowed 4 Divorced Black 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown Chicken Catcher Poultry permit. Pages 1 and 2 should be file Department of Heelith and Mental Hy Important: If item 27 is marked other any liviny or other traumatic event, 2008. 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James L. Hammond Virgie Prideaux 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12697 Greensboro Rd., Greensboro, Maryland Ida May Walkley/Caregiver Baltimore, 20b. Place of Disposition (Name of commetery, crematory or other place)
Eastern Shore
Veteran Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Dec.2, 2009 Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 Physician d disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ξ Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No page 1 Yes or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) P 1 Yes 2 The 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a pellil 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Doo47534 November 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wafik Zaki, MD 920 Market Street, Denton, Maryland 21629 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 24 MARJORIE GODING KUPTEC 2009  $\mathbf{A}^{\mathsf{M}}$ 9:51 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1834 ST. MARY'S ROAD CHESTER QUEEN ANNE'S Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days 92 Months Hours FEBnth, Bay, Yell'917 MATNE **Director** 004-01-4999 Usual Residence of Decedent 10b. County 10c. City, Town or Location items 23a or 28a-1 5110 ner must be notified at 10d. Inside City Limits Director **MARYLAND** QUEEN ANNE'S 1 Yes 2 No CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 1834 ST. MARY'S ROAD 21619 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 X Widowed 4 Divorced Specify: WHITE Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. ANALYST 12 CIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked of r other traumatic evel 2 IVAN GODING UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS KUPIEC/NEPHEW 13203 MOUNTAIN ASH COURT, WOODBRIDGE, VA 22192 20a. Method of Disposition 20b. Place of Disposition (Name of MARY LAND) 20c. Location - City or Town, State DECEMBER 1 Department of Important: If it any injury or conce. 1 X Burial 2 Cremation 3 Removal from State CEMETERY-HURLOCK 2009 HURLOCK, MD 4 Donation 5 Other (Specify) Signature of Funer Service Licensee FELLOWS, Addreckenbein & Newnam Funeral Home, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 the disease, or complication art failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heal Immediate Cause (Final Physician disease or condition resulting in death) Medical (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Shknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? To the Hospital or Attending Physician: 25. Was case referred to medical upleted filled in by the funeral director, 26. Place of Death (Check only one) Be 1 Yes 2-No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State 24 hours Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

DHMH 17 Rev 7/2009

Registrar

venus

NOV 24 2009

THOMAS WALSH, M.D.

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

115 SALLITT DRIVE, STEVENSVILLE, MD 21666

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State Amended#8perFH FCHD,KS,F Registrar	and / Depa CHD1142	artment of F Gificate of D	lealth and N De <i>ath</i>	lental Hy	giene Reg. No.	2000	1.0	1159		
			Decedent's Name (First, Middle, Last)				2. Date of De	-41-	200.	3. Time o	of Death		
	Physicia Medic		Sara J. Knox				Month Novembe	par Day	0, 2009	3:2	Oa M		
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. (	County of Deat		<u> </u>		
			Montgomery Village Health Care		Montgo	mery Vil				gomery			
	Funeral Director		1 M 2 F	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)	Co	thplace (State untry)	-		
			213-24-9008 82 Usual Residence of Decedent			l	July 1		99-  M	aryland			
	land shov d at	tor	10a. State 10b. County 10c. 0	City, Town or Lo	cation					10d. Inside C	ity Limits		
	Mary 28a-f otifie	Director	Maryland Montgomery C1	ry Clarksburg					1 □ Y				
	h the kaor; ben	al D	10e. Street and Number		10f. Zip Code			10g. Citiz	zen of What Co	ountry?			
	th wit	Funeral	12805 Shawnee Lane			0871			United				
_	or ite	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in I Armed Forces?  1 □ Yes 2 1 ☑ No		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - A Black, V						
3	safteral",	ed b	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🙀 No	Specify:		Specify: White					
ۍ -	2 hour	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation luring most of work	na .	16b. Kin	nd of Business				
9500-5121	filed within 72 hours after death with the Maryland at Hygiene than "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life, Di	O NOT use retired)	-							
N	Hygie Hygie other ent, th	Be (	17. Father's Name (First, Middle, Last)	Ele	ctronic	Assembler 18. Mother's Nam			ital Sc	ciences			
<u>a</u>	be fill ked c	၉	Keefer Adkins			Lottie R		ivialueri S	urraine)				
Maryland 2	hould and M s mar umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura		er, City or T	own, State, Zi	p Code)			
Σ	nd 2 sl and 27 i n 27 i er tra		Sally Hoffman / Daughter	12805	Shawnee	Lane, C1	arksbui	g Ma	ryland	20871			
ore O	of He of He If iter			. Place of Dispos			Date		cation - City or				
Ĕ	. Page tment tant:			-	formed Co	111/25	/2009	Mid	dletowr	Maryl,	and		
Baitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	St.	. Name and Addres	s of Facility uneral Ho	mes P.	Α.					
_	452 00	-	222 Part 1 Enter the disease or conflictions that sourced the de	116	21 Onnees	intown Pi	ko Ero	dori	ck, Mar				
ı.			23a. Part 1. Enter the disease, or comblications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	aui. Do not ente	r tile mode or dying	g, such as cardiac (	ir respiratory ar	rest,		Approxima Interval Be Onset and	tween		
	Physician, Medical		disease or condition resulting in death)  a. Due to (or as a conse	CV~	chic c	bstreet	ine In	Jus	54.61	Onbot and	Douth		
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
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	cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last  Due to (or as a conse		orillat	70-							
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S	certifi nding use at	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg		1			2	3d. Date of de	liverv			
gox	e atte	Physician/M	in the past 12 months?  1  Yes 2 No  1  Pregnant at time of		Ctopic pregnance Other (specify)	у			Month		Year		
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5	oital o	alc									- 1		
	Hosp 24 ho Fune eted f	Medical	29a. Certifier 1 Certifying Physician: To the best of my kno (Check 2 Medical Examiner: On the basis of examinating the control of the contro	tion and/or invest	igation, in my opinio	n, death occurred at	the time, date a	and place, a	and due to the	cause(s) and ma	anner stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier	Thy knowledge, d	29c. License		e, and due to th		and manner as signed (Month				
			Winy Gants		DUI	162 m	0	No	rembr	x 2 co	G		
	2		30. Name and address of person who completed cause of death (Ite		rint)	_							
				ictor ?	31116	Come	SWFCN.	n L	VD SC	874			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy N. Krabbe Month Day Tear Voventee 1003 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACKIMOVE-WASHING to Medical C Avundel 1survice 8. Date of Birth
(Month, Day, Year)
Feb. 18,1926 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 160-20-0786 83 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 334 North Drive 21146 USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. unk \$ 1 Never Married 2 X Married Renal Kenth 21215-6036 1 ☐ Yes 2 XNo Specify. White Completed 3 Widowed 4 Divorced Specify: Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Nurse Health Care permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert N. Nicholson Martha Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon E. Krabbe / Son 10528 Willow Vista Way Cockeysville, MD 21030 Date 25, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 7. 25 2009 Baltimore, MD Lorraine Park Cemetery 21. Signature of June al Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) NEUMONE Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-transity that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 OBSWEETINE Shee p Aquea 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive Hesti 24a. Was an certificate has autopsy performed 2 🗌 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 Tes 2 🗌 No s after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier November 19 2009 到时 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+1 31. Date filed (Month, Da

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Dav

1. Decedent's Name (First, Middle, Last) **Physician** ROBERT LEE MILLS, JR. 11/21/2009 1957hrs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-30-8307 77 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Pocomoke City Worcester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö pe 2211 Old Snow Hill Road 21851 IISA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Salesman Wholesale Foods 10 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Be Robert Lee Mills Helen Howeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 8 5 1 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra 2211 Old Snow Hill Road, Pocomoke, Geraldine Mills/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) First Bapt. Cem. 11/25/2009 Pocomoke, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. Mn an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, attended to the shock, or heart failure. List only one cause opeach line. Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in the land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate | 1 ☐ Yes 2 ☐ Yo 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 0 6 2 1 7 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 11/23/09 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD (C SATYAL, MI) 1604 MALKE POLOMOKE GTY MD 21851. 1604 MARKET ST 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Sherry E. Mills 6:10p November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth
(Month, Day, Year)
Anril 9, 1960 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 M 2 X F **Director** 49 218-74-1046 Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12005 Warner Road # B 21757 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 and Mental Hygiene.
is marked other than "natural", 1 ☐ Yes 2 🔀 No Specify: 3 🗌 Widowed 4 🔲 Divorced Year or Dates. White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wal Mart Door Greeter/Safety Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willard L. Fitzwater Joyce Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Edward L. Mills/ Husband</u> 1013 G. Noland, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Boyds Presbyterian Cemetery 4 Donation 5 Other (Specify) Boyds, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOXIC RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TOUTE RESPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, VANCOMYCIN RESIDENT URINALY PART INFECTION 1 Yes 2 No 3 Probably 4 Unknown ANEMIA 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 No Jas prior to completion of cause of death? 2 🗌 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ this ( 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ANTIGAM ST AMAKO-WIRTON 2009 Registrar's Signature 31. Date filed (Month, Day State back Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 11:30 PAUL MARTIN November PM DANIEL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 15 M 2 🗆 Months **Director** 225-04-7511 44 1964 Dec. Usual Residence of Decedent or 28a-f show notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

Rant: If item 27 is marked other than "natural", or items 23a or 28a-f sho itury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No Maryland Frederick Thurmont 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 22 Tacoma Street 21788 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Š 1 Never Married 2 Married ☐ Yes 2 XX No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Power Utility College (1-4 or 5+) High-Voltage Lineman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Edward Martin Sharon Ann Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon MArtin / Mother 1515 Brigham Rd., Richmond, VA 23226 Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Nov. Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. MD 21701 Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IXTAD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death. **To the Funeral Director:** After this certificate l completed filled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 400. W. 7th Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASAN, MO ()21701 31. Date filed (Month. Day. 32. Registrar's Signature State NOV Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 20 2009 Physician/ Harold Hendrix Martz Jr 4:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 8. Date of Birth (Month, Pay, Year) Dec. 1, 1955 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 D F Months Hours Min. Mary Land Director 212-62-3457 53 Dec. Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8208 Morning Dew Lane 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 72 hours after þ 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Vice President Landscaping Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ျှ Harold H. Martz, Sr. Esther V. Delaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8208 Morning Dew Lane Frederick, Maryland 21702 Carla Y. Martz / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If ite Date November 1 🖾 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 24, 2009 any injury Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Conte disease or condition resulting in death) 0000 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dide to (or as a cons death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending pure 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the signed by ti d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ဂ 1 Yes empatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 14 Natural death. n 24 hours after death. e Funeral Director: A leted filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. mpleted (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

State

only one)

29b. Signature and title of certifier

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 Alexandria Signature

Registrar DHMH 17 Rev 7/2009 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear Naida F. Montgomery 2009 30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 LEN BURNUE BALTIMORE WASHINGTON MED CTR If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
June 06, 1918 ANKE ARUN DEL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛛 F 91 Director 301-14-9138 Yrs Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Severna Park item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director MD Anne Arundel 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 475 Severnside Drive 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11 Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married If Yes Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Graf Fern Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is 1 Marlene Hellett / Daughter 475 Severnside Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 30, 2009 20c. Location - City or Town, State St. Joseph Cemetery 4 Donation 5 Other (Specify) Sylvania, Ohio Signature of Funeral Service Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ UROSEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner YGARS DETNENTIA Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RECTAL CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: page certificate 2 🗌 No Yes 2 N 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation within 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Holdical Examiner: On the basis of examination and/or investigation, in my opinion, death becurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) Loven 130059190 NOV. 23 2009 NH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAPFOT - BONNE BALTI MORE WAS HINGTON MEDICAL 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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	-	For State Registrar	Sta	te of Mary	land / Depa/ Cer	artment of tificate of		and N	Mental Hy	•			
Physician	,	Decedent's Name (First, Middle	, Last)			imouto or	Douin		2. Date of De		201	9	3. Time of Death
Physicia Medic	al	GEORGE VINCE							NOVEMB				3:15 PM
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Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under		8. Date of Bir	rth		9. Birthp	lace (State or Foreign
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and show	ē	10a. State 10b. County		10	c. City, Town or Loc	cation						10	Od. Inside City Limits
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withir giene ner tha t, the		Elementary/Seconday (0-12)	4	ege (1-4 or 5+)	MECHA	ANICAL E	NGINE	ER		E	LECTR	ICAI	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, L JOSEPH HARRITO	,	WAN					ne (First, Middle, <b>A KIRBY</b>	•	Surname)		
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and 2 Health em 27 ther tr		CAROL McGOWAN/ 20a. Method of Disposition	WIFE			QUARTER	CREEK						
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mit. Ppartme	1	21. Signature of Funeral Service L			ENTER 22	. Name and Addr	ess of Facilit	ty		L			
permi Depar Impo any ir		) Sun-	KI	ul		LLOWS,HI			& NEWNA	AM FU	UNERAI E. MD	L НО 216	ME, P.A. 17
Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications nly one cause	that caused the on each line.	death. Do not ente	r the mode of dyi	ng, such as	cardiac	or respiratory ar	rrest,			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	T a. Di	ue to (or as a co	nsequence of):								1/
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	s, outcome of p Live Birth 2 L Pregnant at tim Unknown	Fetal death 3	Ectopic pregnar Other (specify)	псу				23d. Date (		ry Day Year
that th	by Pr	Part II. Other significant condition	ns contributin	g to death but n	ot resulting in the u	nderlying cause g	jiven in Part	I.	23e. Did t	tobacco ι	use contribu	ute to th	e cause of death?
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To the Constitution		29b. Signature and title of certifier	-	-		29c. Licens	se number				te signed (/		
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10.		30. Nary and decress of person v	vho completed	2540	(Item 23a) (Type, P	rint) I.E. ROAD -	CENT	REVI	LLE, MD	216	517		
State		31. Date filed (Month, Day, Year)		32. Registrar's		LL ROMP,	J.1.1.						

DHMH 17 Rev 7/2009

Registrar

NOV - 6 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Lena Mills Рм :45 Medical Decemb 4b. City, Town, or Location of Death 4c. County of Death Washington 4a. Facility Name (if not institution, give street and number) Examiner Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - XTF Hours Min 8 - 2 1 - 1 92 7 579-28-8593 82 **Director** Washington DO Usual Residence of Decedent show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Clear Spring 1 Yes 2 No 28a-f 10e. Street and Numbe 10f. Zip Code 21722 ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be 12509 Boyd Road Funeral with U.S.A. Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muny or other traumatic event, the Medical Examiner muny or other traumatic event, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? by 1 Never Married 2 X Married Specify: white If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) state govt. office manager 12th grade 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angela Camaratta Andrew 2 Paterno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Boyd Rd.Clear Spring, MD 21722 Wayne E.Mills husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 5. Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Little Rose Hill Clear Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee HOMe. Approximate Interval Between Orset and Death 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded to cause (Final disease or condition) Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esque itially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transl that initiated events resulting in death) Last Due to (or as a Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) g Unknown iis certificate has been signed by the director, page 2 should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ente 1 Yes Be 25. Was case r d to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ည 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be determined

Baltimore, Maryland 21215-0036 Box 68760 P.O. Records, within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page Division of Vital the Hospital or Attending Physician: Certificate: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -CA. HR 146-12 ANVIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 04 Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

State Registrar th, Day, Year)

31. Date filed (Month, Day,

32. Registrar's Signature

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 29, 09^{Year} **Physician** 4:30 A M Doris Lee Adkins Quillen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10836 Cathell Road Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug. 7 ; 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Country) 1 □ M 2 🖒 F PA 82 213-22-7334 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10836 Cathell Road 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ M∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: white 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hy 17. Father's Name (First, Middle, Last, Be Herman Adkins Mary Holloway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debbie A. Carper - Daughter 2393 Broad Run Crt. Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ *Burial 2 ☐ Cremation 3 ☐ Removal from State Buckingham Cemetery Dec. 3, 09 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Burbage Funeral Home 108 William Street Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** A DioneyopATH SEVENE VICATED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PETTICAL Due to (or as a consequence of Examine The law requires that the death certificate be executed ending physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending I be detached for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 Tyes 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to edical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) After thi 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Division Hospital or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mi) ASTAWENA 10320 32. Pegistrar's Signature 31. Date filed (Mont State 2009 Registrar

**Funeral** 

**Director** 

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examirer must be notified at

Hygiene.

Immediate Cause (Final **Physician** Acute Respiratory Failure /Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit Pneumonia resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Atrial Fibrillation his certificate has been signed by the attending princetor, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Diabetes Mellitus Completed Hypertension 25. Was case referred to medical examiner? Be 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical 29a, Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number D41162 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Ganti M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 Registrar Ensua DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmended#1perMD FCHD KS 11/30 Corrtificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2009 **Physician** Month Rosa Marie Rickerds November 8:20A Rosa Marie Rickerts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Months Days Hours 1 ☐ M 2 💢 F 91 219-64-7499 June 17, 1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 245 Lake Coventry Drive 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Completed by Specify. Specify: 3X Widowed 4 ☐ Divorced Year or Dates White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) William Monroe ည Rosa May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21702 19a. Informant's Name/Relationship (Type. Print) Rodney Ε. Brown - Son 245 Lake Coventry Drive, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 11/22/09 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licensee. Novert 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) November 21, 2009 Germantown, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 19 2009 Allen Gennis Ramsev 10,35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 11, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1x M 2 □ F Virginia 217-34-0295 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2X No Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4904 Post Court 21771 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Salesman Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Walter Ramsey Hager Mae Seabolt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Post Court, Mt. Airy, Maryland 21771 Patty Smith / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery 11/24/09 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Frederick, Maryland ROBERTO E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part T. Enter the disease Immediate Cause (Final Onset and Death Paysician/ PENAL CELL PARTINOMA METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CANCEL LIVER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ME FASTASIS performed? Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, t 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA me lyon 121936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Donelson, MD, 65C Thomas Johnson Drive, Frederick, MD 21702

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

parke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Year

PM

4:112

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

5 days

30 years

Year

Day

1 ☐ Yes 2 ☐ No

autopsy performed? Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

11/21/09

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one

1 ☐ Yes 2€No

Illinois

White

Records, Division of Vital or Attending Physician:

within 24 hours a completely State Registrar DHMH 17 Rev 1/2001

s after death.

filled in by the

rwine, University of Maryland Medical Cerrer
32. Aggistrar's Signature, Mariaileen 31. Date filed (Month, Day, Year)

Jourwine

28a. Date of Injury (Month, Day, Year)

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be

determined

1∐Yes 2⊠No

examiner?

27, Manner of Doath

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Be

Medical Certification: To

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 5. Greene St. Baltimore, MD

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 □Yes 2 □ No

1529227378

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 7:10 am George Rutemiller Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Arundel 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XX M 2 1 F Months Days Hours Min. Country) (\$9717,P\$197394) PA 384-32-5068 75 **Director** Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City. Town or Location death with the Maryland aţ Director r 28a-f s notified 1 Yes 2 X No Anne Arundel MD Annapolis 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funera 21401 USA 200 Kirkley Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Il Hygiene. Officer US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even Henrietta Marie Fischer Oren George Rutemiller Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Kirkley Rd. Annapolis, MD 21401 Mary Rutemiller Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 11/25/09 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 card disease or condition Medical resulting in death) Due to (or an Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐N ☐ Yes 2 ☐ No 25, Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t Natural Accident injury 5 Pending work thin 24 hours after death.

the Funeral Director: After management of the function of the func 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYDOND E. BANFER 50 349 BRAVERSON ST = 201

32. Registrar's Signature

KAYMIND E. BANFER MO

31. Date filed (Month, Day, Year)

36371

23

EDGEWHER NO 21037

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDERI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town 4c. County of Death ARUNDEL MEDICAL ANNE CENIGR 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign (Month, Day, Year) 1/16/1938 1 X M 2 🗆 F Hours 220-36-9901 Director Washington DC Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel 1 Tes 2 No ShadySide 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4885 Idlewilde Road 20764 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ^{2 No} 1961 þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DC Fire Department SGT. permit. Page 1 and 2 should be filed w Decartment of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Joseph Reed Stella Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois V. Reed Spouse 4885 Idlewilde Road ShadySide, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lakemont Cemetery 11/24/09 Davidsonville, MD 21. Signature of Pureral Service L 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 Daw 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine resulting in death) Last buna!-Physician/Medical death certificate be Box 68760 the attending pl IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 9 Unknown Month Day been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? 1 Yes 2 🗌 No of Vital the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: 9 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this upleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury Pending work? Division hours after death. Ineral Director: A 2 🗌 No 2 Accident 3 Suicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. PULM. (Type, Print) DR. Name and add 670 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

			y <b>pe or Prin</b> State of Ma				lealth and N			egible.		
		1 - State Registrar			•	rtificate of			Reg. N2	009	40175	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  MARIE	SCHLEY					2. Date of De 11-22-2		Year	3. Time of Death 4:48 A M	
Examin	er	4a. Facility Name (If not institution, give single 745 LAUREL AVENUE						th 4c. County of E				
Funeral Director		5. Social Security Number 198−16−1044 6. Sex	7. Age	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3-3-19)	th ny, Year) 24	9. Birthplace (State or Foreig Country) 4 PENNSYLVANIA		
and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	cation					10d. Inside City Limits		
ne Mary 8a-f sh	ctor	MARYLAND WORCESTER	<u> </u>	OCEA	N CI						1 <b>X</b> Yes 2 □ No	
th with the 23a or 2	Funeral Director	10e. Street and Number 745 LAUREL AVENUE				10f. Zip Code 21842			10g. Citiz	ren of What Co	untry?	
be filed within 72 hours after death with the Maryland Hydiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Wildowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 □Yes 2 N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: W		
n 72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)		a. Deced (Give	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kin	d of Business/	Industry	
d withi	Somp	Elementary/Secondary (0-12)	College (1-4or 5-	+)		TRESS		PRIVATE CLUB				
e d all be	To Be (	17. Father's Name (First, Middle, Last)  LOUIS RESZKOWSKI	ame (First, Middle, Maiden Surname) ILIPOWSKI									
ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print)  JUDITH G. RIVES / DAUGHTER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 745 LAUREL AVENUE, OCEAN CITY, MARYLAN									21842	
Pages 1 ment of H ant: If ite ury or otl											Town, State DELAWARE	
permit. Page Department Important: I any Injury o once.	21. Signature of Fune all Service Licensee  MELSON FUNERAL  22. Name and Address of Facility SERVICES, LTD  43 THATCHER ST, FRANKFORD, DE. 199											
Physician /Medical Examiner	er	23a. Part 1. Enter the dise st., or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a	a consequence	e of):		ng, such as cardiac		rrest,		Approximate Interval Between Onset and Death	
ate be executed hysician and he burial-transit	cal Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Chroni Due to (or as a	a consequence	e of):	reilure	edleell:	lung 89	+NCE	R		
Attending Physician: The law requires that the death certificate be executed refarth.  After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								3d. Date of del Month	ivery Day Year	
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The law recate has bee	Completed								psy orm <u>ed?</u>	prior to death?	ntopsy findings available completion of cause of	
iclan: The	BeC	25. Was case referred to medical examiner?					26. Place of Deat	1 ☐ Yes th (Check only o	2 MNo one)	1 □ Yes	213490	
Physi r this o	<u>2</u>	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatie 28a. Date of Injur	nt 2 ☐ ER/0	Outpatier  Time of		4 LI Nursing no	ome 5 Resi 28d. Describe			cify)	
	Certification:	1	(Month, Day	y, Year) ury - At home,	Injury	Wor	k? [™] Yes 2 □ No		Street and	d Number or Ri	ural Route Number,	
Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowled	ge, deat	h occurred at the ti	me, date and place opinion, death occu	, and due to the	cause(s)	and manner a	s stated. to the cause(s)	
To the I within 2 To the I complet	Medical	one) 29b. Signature and title of certifier	and manner sta	ned.		29c. Licens	e number			e signed (Mont		
		I week R. h	been.	20		H 00	66462		11	-23-	,4	
BA 6		30. Name and address of person who cor JEFFREY SCHEIRER,					TN. MARVI	AND 2	1811			
Sta		31. Date filed (Month, Day, Year) NOV 2 4 200	32. Registra	ar's Signature	) I	المالات وتبدين	in initi	J. 1111 6 6.	.011			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Nov. **Physician** 24, 12:25 PM William Daniel Sweeney /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 24 Coastal Drive Berlin Worcester 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 2, 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, **Funeral** ^{Year)}29 Min. Months Days Hours 169-20-5385 Jan. 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examination must be notified at 1 ☐ Yes 2 No Director MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 24 Coastal Drive 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 14. Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Navy U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William P. Sweeney Edna Poff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Sweeney - wife 24 Coastal Drive Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. Nov. 25,09 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William Steet Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician enc 00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

law requires that the death certificate be executed P.O. Box 68760 Records. Division of Vital Hospital or Attending

attending physician and for use as the burial-transit cate has been signed by the page 2 should be detached certificate this certific After this funeral c death. n 24 hours after death.

Be Funeral Director: A pletely filled in by the fu To the I within 2.

28a-f show

Baltimore, Maryland 21215-0036

State Registrar

Medical

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

0

29c. License number

1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Sute 403

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Droopfiller

and manner stated.

NOV 2 4 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Jak Fraure All Copies Are Legible.

Amend 23a per phys. G900 2725/16 The The Amend 23a per phys. G900 2725/16 The The The Amend 23a per phys. G900 2725/16 T Reg. No. 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}20,2009 **Physician** Wilbur Shaffer November 1341 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/01/1941 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min West VA. 281-36-9234 67 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinar must be notified at ance. MD Anne Arundel Arno1d 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 295 Broadwater Road 21012 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Jife. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvert Shaffer Myrtle Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Louise Shaffer Spouse 295 Broadwater Road Arnold, MD 21012 20b. Place of Disposition (Name of At Paneters Cremeters or of the place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/21/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 Vates 23a. Part1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Salmonella Infection Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or, e Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.

Ye hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) Ö is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 1 ∐ Yes 2 ⊡ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 (No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prior

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year

NOV 24

32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

NOV 24 2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

For State Registrar

Physic /Medi		1. Decedent's Name (First, Middle, Last)  Marie B.	Vaughn				November	Day Year <b>26,2009</b>	3. Time of Death $9wP$ , M,
Exami		4a. Facility Name (If not institution, give str National Lutheran	· ·		4b. City, Town, or <b>Rockvil</b>			4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1	7. Age (In yrs.	last birthday) 4	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Feb. 21, 1	Year) Co	thplace (State or Foreign buntry) kton, MD
h the Maryland or 28a-f show a notified at	Director	Usual Residence of Decedent		y, Town or Lockvil			100	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🗷 No puntry?
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evariner must be notified at	by Funeral	1 Never Married 2 Married	#3 Was Decedent Ever in U. Armed Forces? 1 \( \subseteq \text{tes} \) So No If Yes, Give Year or Dates:	1	20850 Was Decedent of Hi f Yes, specify Cubai ☐ Yes 25 No	spanic Origin? (Sp n, Mexican, Puerto Specify:		USA  14. Race - Ame Black, Whit Specify: wh	e, etc. nite
nd 21215-0036 be filed within 72 hours aft tal Hygiene. d other than "natural", or event, the Medical Every	Be Completed	15. Decedent's Educa (Specify only highest grade of 15. Elementary/Secondary (0-12) 12.  17. Father's Name (First, Middle, Last)	completed)  College (1-4or 5+)	(Give life. L	kind of work done do DO NOT use retired, emaker	luring most of work ) 	e (First, Middle, Ma	own home	
'e, Maryland 1 and 2 should be file Health and Mental Hy tem 27 is marked oth	To	William J. Barry  19a. Informant's Name/Relationship (Type  Kenneth Vaughn (  20a. Method of Disposition	son)	1150	4 Alcinda	and Number or Rui	ral Route Number,	City or Town, State,  omac, MD 2  Oc. Location - City or	20878
Baltimore, permit. Pages 1 an Department of Hea Important: If item: any injury or other once.		12DBurial 2 ☐ Cremation 3 ☐ Ret 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Gr	ace Ep	sition (Name of natory or other place oiscopal (	Church Ce	4,2009 m.	Wilmingto	on, DE
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	tions that caused the deat cause on each line.  Brain  Due to (or as a conseq	h. Do not ento		<b>ilmington</b> g, such as cardiac			Approximate Interval Between Onset and Death
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Division of a or Attending Phy after death.  Director: After this din by the funeral d	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Rending investigation 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury ome, farm, str	M 1 🗆	yat k? Yes 2∐No	28d. Describe how 28f. Location (Str. City or Town,	eet and Number or F	Rural Route Number,
Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		cian: To the best of my knote: To the basis of examination and manner stated.						
To th withir To th	Me	29b. Signature and title of certifier  30. Name and address of person who con	New pleted cause of death (Itel	M O		e number 506 (		od. Date signed (Mor	
S	tate	Samuel G. Malle  31. Date filed (Month, Day, Year)	`	Veirs		ockville	, MD 208	350	
Regis		DEC 0 2 20	109 Menera	B. X	parkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2 0 0 9

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	f Marylan		rtment of H		Mental H			40180	
			Registrar  1. Decedent's Name (First, Middle, I	Last)		Cer	inicale of t	Dealii	2. Date of D	Reg. No. C		3. Time of Death	-
	Physicia		Edward Steven W	harton					Novemb	er 20	2009	2:00 P M	
	/Medic Examin		4a. Facility Name (If not institution, g	give street and num	nber)		4b. City, Town, or	Location of Death		4c. C	ounty of Death	1	-
			CORSICA HILLS				UEEN AN						
L	Funeral Director		215-16-5932	. Sex 1 <b>X</b> IM 2□ F	7. Age (In yrs. I		Months Days	If Under 24 Hrs. Hours Min.	(Month, I	Birth Da <i>y, Y</i> ea <i>r)</i> <b>6, 192</b>	Cot	nplace (State or Foreign intry) YLAND	
	dand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation					10d. Inside City Limits	-
	Mary a-f sh	ctor	MARYLAND QUEEN	ANNE'S		CENTRE	VILLE					1 □Yes 2 <b>X</b> No	
	or 28	Director	10e. Street and Number		*	-	10f. Zip Code			10g. Citize	en of What Cou	ıntry?	-
	s 23a		667 POPLAR SCHO				216				ED STAT		_
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. Marical Event must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married	Armed For 1 X Yes If Yes, Giv	^{2□No} 194	2- 1	Vas Decedent of H Yes, specify Cuba □Yes 2X No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or f o Rican, etc.)		<ol> <li>Race - Amer Black, White, Specify: WH]</li> </ol>	, etc.	
2-003	72 hours 'natural'	Completed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's  (Specify only highest)	Year or Da  Education  grade completed)	ates: 194	16a. Deced	ent's Usual Occup	during most of wor	king		d of Business/li		_
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2	other other	Be C	17. Father's Name (First, Middle, La	st)		1111	OHIME OF	18. Mother's Nan	ne (First, Midd				-
Na Na	should be and Menta s marked umatic ev	To B	STEVEN WHARTON	1				GLADY	S MURP	НҮ			
<u>a</u>	2 sho n and ls ma rauma		19a. Informant's Name/Relationship			I	g Address (Street				,	•	
ນົ	1 and Health em 27	1	GRETCHEN BONES  20a. Method of Disposition	S/DAUGHTE			OPLAR SCI	HOOL ROAL	Date CENT		E, MD. ation - City or T		_
altimor	Pages iment of tant: If ite		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	emetery crem CHE	SAPEAKE ION CENT	e) NOVEN	IBER 21 009			E, MARYLAND	
D	permit. Departr Importa any inju		21. Signature of Euneral Service Lie	censee	1	FE	Name and Addre	ELFENBEIN	N AND N	EWNAM CENTR	FUNERAL EVILLE	L HOME, P.A. , MD 21617	
П			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cally one cause on e	aused the death	n. Do not ente	er the mode of dyir	ng, such as cardiad	c or respiratory	/ arrest,		Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (	or as a consequ	uence (f):	· Four	172			j.	Ukars	
		ř	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. The proposequence of:									years	-
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DOX O	sath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	1 ☐ Live t 4 ☐ Pregr	come of pregna birth 2□ Feta nant at time of c	I death 3	Ectopic pregnanc	у		_ 23	3d. Date of deli Month	very Day Year	
5	at the d by th	hys	9 ☐ Unknown	9 □ Unkn									_
cords,	en signed	þ	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the un	iderlying cause giv	en în Part I.			e contribute to	the cause of death? obably Unknown	
necc	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed							24a. W au pe 1 □ Ye:	itopsy erformed?	prior to death?	topsy findings available completion of cause of 2 \sum No	
\ [2] \	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea					
5	Phys r this eral di	.T	1 Yes 2MNo 27. Manner of Death	28a. Date	Inpatient 2  of Injury	ER/Outpatien 28b. Time of	t 3 🗆 DOA	4 Nursing F		esidence 6 be how injury	Other (Spec	cify)	-
VISION	nding ath. r: Afte e fune	atior	Natural 5 Pending 2 Accident investigation		th, Day, Year)	Injury	28c. Injur Worl	kí?  Yes 2 □ No		, ,			
	after des atter des Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	of Injury - At ho	ome, farm, stre	eet, factory, office		28f. Location City or	n (Street and Town, State)	Number or Ru	ıral Route Number,	
	To the Hospital or Attendi within 24 hours atter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying  2 Medical Ex	Physician: To the caminer: On the b	e best of my kno pasis of examina ner stated.	owledge, death ation and/or inv	n occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to t urred at the tin	the cause(s) and p	and manner as place, and due	s stated. to the cause(s)	
	Within To th	Me	29b. Signature and title of certifier	MAN	1 m		29c. Licens			29d. Date	signed (Mont)	h, Day, Year)	
	510		30. Name and address of person w	ho completed caus	se of death (Item	n 23a) (Type, I	Print) mans	/ sne	East	on. /	hd Z	160)	
Í	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 4	/	Registrar's Signa	d. La	wed .	)					
				7-51		-17							-

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
Amend 19a per Iff (898 12/23/09 dk
State of Maryland / Department of Health and Mental Hygiens

Certificate of Death

Reg. No. 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 12:50 PM 3 2009 December Miriam Ruth Wilk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Gertrude Monastery Caroline Ridgely If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🕅 F 95 221-42-2807 May 18 1914 Director New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14259 Benedict Lane 21660 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Lry or other traumatic event, Ire III teacher Catholic school system 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph T. Wilk 2 Anna Laczynska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14259 Benedict Lane; Ridgely, MD 21660 Sr. Catherine Higley Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or St. Gertrude's Cem 4 ☐ Donation 5 ☐ Other (Specify) Dec 7 2009 Ridgely, Maryland 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smeeting Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARRATTAMIA A CUTE CARDIAC /Medical Due to (or as a consequence of): Examiner ARDIOVASCULAR Teriosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No Ö the detached 9 Unknown 9 ☐ Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by The law requires page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? 1 Yes 2 No certificate Division of Vital Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 251No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZEMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print).

Registrar

State

31. Date filed (Month, Day,

MD

32 Registrar's Signature

690, DENTON MD 216

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 3105 am Norma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Hospice Richey Joseph If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Aug. 1, 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Maryland 1925 Director 84 Aug. 219-18-0929 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No **Maryland** Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 3010 N Ridge Road C607 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Monastery Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Burrier Norman Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Roundhill Road, Baltimore, Maryland 21218 Margaret D'Adamo/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 18. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Owings Mills, Maryland Carrison Forest Cenetery 314 Amanda Heaston 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility MacNabb Funeral Home, P.A. Ole 301 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 10/10 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Norma As endort 1. Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗀 No 3 Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation after deat Director: 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

2

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ASBEIL Month CCILEE D.AMM 2009 acility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, 01 0 4 (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Usual Residence of Decedent 10b. County 10a, State 10d. Inside City Limits MÜ 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 XNo ☐ Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2X No Back Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Son homas 20a. Method of Disposition 1 Burial 2 Gremation. 4 Donation 5 Other (Specify) Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service L censes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OMG Due to (or as a consequence of) Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated experts.) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 2 N 1 Yes 2 🗆 No

**Physician** /Medical Examiner

certificate be executed

Box 68760.

P.0.

Records.

Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28e-f ehow

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permit. Pages 1 and 2 Depertment of Heelth a Important: If Item 27 is eny injury or other trau

2 should be 1 and Mental I

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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traumatic event, the Mudical Examiner must be notified at

Examiner sete hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Physician/Medical Completed by this certificate has To the Hospina.
within 24 hours effer death.
To the Funeral Director: Affer this cenum-Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Duknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient

1 🗌 Yes 26. Place of Death (Check only one) 4 Horsing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 Yes 2 No 27. Manner of Death 1 ☐ Matural 5 Pendina 2 Accident

3 Suicide

4 Homicide

29a. Certifier (Check only one)

25. Was case referred to medical examiner?

investigation 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Yes 2 No

Other:

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 loch River Alvd Baltrowne

C. Buller MI 2009 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State State Registrar amend 24,27 per Dr. g898 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 10-HHNIE 2009 Nov 2 1001 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.
21 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth **Funeral** Year) 1 X M 2 □ F Months Vre Director 11/13/09 infant Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 □Yes 2√ No MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 5379 Harper Farm Road #2 21044 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify. \$ Specify: black 3 Widowed 4 Divorced 'naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Abbey Joanna Nelson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital 5755 Cedar Lane Columbia, MD 21044 Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Sign sture of Funeral Service/ icensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street xector m Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEVERE Due to (or as a consequen /Medical **Examiner** REMATURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burlal-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Por Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown · has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 2 No of Vital 1 ☐ Yes 2 No Hospital or Attending Physician: '4 hours after death.' Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 SOther (Specify) Hospital: 1 Yes → No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA HOSPITAL 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier Neborah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doorfer NM Deborgh egistrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibles AMEND ITEM#16a, b, perFH, G898, TZ/1/09, WS State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dec Michael William Brice Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. (Month, Day, Year) Director 212-48-6716 64 MD Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he motified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 Borman Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1X Yes 2 [ If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 Widowed 4X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) **Technician** Elementary/Seconday (0-12) College (1-4 or 5+) Lucent Technologies Telephone Company 12th grade Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Weddon Fuller Annie Mae Brice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 James Brice-Brother 4408 Old Court Road Apt K, Pikesville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Garrison Forest Vet 12/17/09 Owings Mills, MD 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, ure of Funeral Service License Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Interval Between mm-plate Cause (Final Onset and Death Smill Physician/ Non se or condition resulting in death) Medical Due to (or as a consequence of): , Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed amie and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnal cy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Dav Year Pregnant at time of death Unknown Yes 2 No the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 Yes 2 No Yes 2 4 No 25. Was case referred to medical exampler?

1 ☑ Yes 2 ☐ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident
3 Suicide Investigation
6 Could not be М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D 3/4 L 4 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, MD 12/14/65 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 frite 300 BALTIMORE MP 2128 N. ENTAW HOS 14001 MD 32. Registrar's Signature State

Registrar

DHMH 17 Rev 7/2009

09-09551 Deborah Beard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Deborah Beard Month Day December 8, 2009 Medical Examiner 1838 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Director Months Days Hours Min 214-78-8372 Country) M 52 07/26/1957 MD Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD NΑ BALTIMORE or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5522 Midwood Ave. Apt. 21212 Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Mamed 2 White, etc. Mamied Yes 3 Widowed Divorced If Yes, Give Year ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner Black 1 Yes 2 X No specify: Specify: δ, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade lyr Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilie Miller Albert Beard Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ohio 45231 Albert Beard, Jr. -Brother 8553 Daly Road Apt 12, Cleveland, 20a. Method of Disposition timore, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Cremation 3 1 X Burial 2 Removal from State permit. Pages
Department of
Important: I Parkwood Cemetery 12/18/09 Baltimore, MDDonation 5 Other Specify: 21. Si natur of Funeral Service Licensee 22. Name and Address of Facility 21215 March Fun. Home 4300 Wabash Av. Balto. MD 23a. Part I. Enter the disease, or complications that cauted he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval fallure. List only one cause on each line. en Onset and /Medical a. Blunt Force Injuries of Head Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown <u>о</u> by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? page certificate Yes 2 1 V Yes 25. Was case referred to medical director 26. Place of Death (Check only one) of Vital æ examiner? Hospital: 1 ✓ Inpatient 2 this ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes After 27. Manner of Death 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Subject assaulted FOUND: Natural Director: ed in by the f Pending Yes 2 V No death. Dec 3, 2009 2 Accident 0600 hrs Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 5222 Midwood Avenue, Baltimore, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 9, 2009 n V 30. Name and address of person who completed cause of death (item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State

Registrar

gistrar's Signatu Lucua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 15, Thomas Ringold Blunt, Jr. 2009 5:36 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3113 Hernwood Road Baltimore Woodstock Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1**X**M 2 □ F Hours Months Min 03/11/1925 218-18-9585 84 **Director** Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Woodstock 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3113 Hernwood Road 21163 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Surveyor Baltimore County anould be file th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Thomas Ringold Blunt, Sr. Mary Thomasine Atherton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah A. Groves/Daughter 1233 Pouder Road Sykesville, MD. 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State 4 Donation 5 Other (Specify) Granite Presb. Cem. 12/19/2009 Woodstock, MD. 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road 21. Signature of Fineral Service Licenses & Crematory, Winfield, MD. Keller a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) curces mouths Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? ð Records, 1 No 3 Probably 4 Unknown Completed hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 so completed filled in by the funeral director, page 2 so autopsy performed 2 🗆 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Matural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 484 ecember 16 2009

State Registrar 31. Date filed (Mc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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egistrar's Signatur

		•	1 - State of Maryland State of Maryland		artment of Health and tificate of Death		ene g. No. 2009	40188	
	Physicia		1. Decedent's Name (First, Middle, Last) Frances Barbara Clark			2. Date of Death Month December	Day Year	3. Time of Death 4:28 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Center		4b. City, Town, or Location of Dea		4c. County of Death		
H	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>ln yrs.</i> late 1 ☐ M 2 🗓 F 73	st birthday) Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birth 17.1935 M	aplace (State or Foreign aryland	
	ryland I-f show ied at	Director		rry Ha		peddingor		10d. Inside City Limits	
	with the Ma 23a or 28s 1st be notif	Funeral Dire	10e. Street and Number 4208 Darleigh Rd.	LLY III.	10f. Zip Code 21236	10 U	10g. Citizen of What Country? United States		
936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates.	If	Vas Decedent of Hispanic Origin? (3 Yes, specify Cuban, Mexican, Pue Yes 2 🔯 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: whi	etc.	
21215-0036	vithin 72 hour piene. It than "natu the Medical the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+) 2	(Give k life. DC	lent's Usual Occupation kind of work done during most of wo D NOT use retired) maker	orking 1	6b. Kind of Business Ir	ndustry	
and	be filed w lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Vincent Francis Carlin		18. Mother's N	ame (First, Middle, Ma ne Marie (	,		
Maryland	12 should alth and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Christopher Clark/son	1	ng Address (Street and Number or Fi Hampstead Mexico		ity or Town, State, Zip		
altimore,	Page 1 and lent of Heg int: If item iny or othe		20a. Method of Disposition 20b. Pl	emetery, crem	sition (Name of natory or other place) Faith Cemet.Dec.	l l	Oc. Location - City or T		
Balti	permit. P Departm Importa any inju		21. Signature of Funeral Service Licensee		Name and Address of Facility tchell-Wiedereld 00 York Rd. Ba			8	
	Physician/ Medical Examiner	iner	23a. Ant 1. Enter the disease, or complications that caused the death chock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence f):	er the mode of dying, such as cardia	ac or respiratory arresi	i,	Approximate Inter al Between On it and Death	
09	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last  C. Due to (or as a consequence of the consequence of	ence of):					
. Box 687	requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown   23c. If yes, outcome of pregnant 1 □ Live Birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year	
ds, P.O	luires that then signed by	by	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?	
Recor	The law rec cate has bee page 2 sho	Completed				24a. Was an autopsy perform 1 \(\sum \) Yes 2	prior to co	opsy findings available ompletion of cause of	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Certificate: To Be	1 Natural 5 ☐ Pending (Month, Day, Year)	ER/Outpatien 28b. Time of injury	26. Place of Death (Ch at 3 DOA Other: 4 Nursing 28c. Injury at work? 1 Yes 2 No	Home 5 Residen  28d. Describe how		thospice	
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	il Route Number,	
	the Hospii in 24 hou the Funer ipleted fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and the best of m	and/or invest	tigation, in my opinion, death occurred	d at the time, date and	place, and due to the ca	ause(s) and manner stated.	
Î	To To to		29b. Signature and title of certifier  GOOGF HUMANN, MA		299 License number	179 /	d. Date signed (Month,	Day, Year)	
			30. Name and address of person who completed cause of death (Item Grage Flancus, M) 6	1011	V. Charley 57	Tows	an, Mo	21204	
	Sta Registra		31. Date filed Month Pay, Year, 2009	8. p.	arke)				

		-	For State Registrar	State of	Maryland		rtment of l		l Mental Hy	giene Reg. No. 2009	40189
	Physicia	n/	1. Decedent's Name (First, Midd Martha Junio						2. Date of De Month		3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution				4b. City, Town, o	r Location of Dea	<u>l Dec</u>	12 2009 4c. County of Dea	
1	j		Stella Maris				Timoni			Baltimo	
-1	Funeral Director		5. Social Security Number 214-62-8299	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. las		Months 0ays	If Under 24 Hi Hours Mi		y, Year) Co	rthplace (State or Foreign ountry) \(\Delta\)
	ind show at	'n	Usual Residence of Decedent  10a. State 10b. Count	у	10c. City	Town or Loc	ation	-			10d. Inside City Limits
	Maryla 28a-f s otified	irect	MD		Balt	cimore					1 🛣 Yes 2 🗆 No
	with the 23a or	Funeral Director	10e. Street and Number 3038 E. Monu	ment Stre	et		10f. Zip Code 2120	5		10g. Citizen of What C	ountry?
р.ш.	e filed within 72 hours after death with the Maryland tall Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🙀 Divorce	Armed Ford	2√ No	If	Vas Decedent of H Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: B1	te, etc.
4:15 p.m 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed		ent's Education hest grade completed) College (1-4	4 or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retired,	during most of w	rorking	16b. Kind of Business Private	s Industry
	be filed withir ental Hygiene ked other tha ic event, the I	Be	17. Father's Name (First, Middle Willie J. Gr			carec	11 101	18. Mother's N	, , ,	Maiden Surname)	
<u>~ _</u> <u></u>	2 should be f th and Menta 27 is marked traumatic ev		19a. Informant's Name/Relation	ship (Type, Print)				and Number or I	Rural Route Numbe	er, City or Town, State, Z	
e T	and 2: Health tem 27		Carla Crowde  20a. Method of Disposition	r (daugnt			N. COL	lingto:	n Ave. ]	Baltimore 20c. Location - City of	
CEMBER 1	Page 1 nent of ant: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State CE	metery, crem nity	cemete:	ry 12/	18/09	Dundalk,	4D
DECEMBER   Baltimor	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Funeral Service	License	ý					havis,Jr. imore,MD	
			23a. Part 1. Enter the discrese, shock, or heart failure. Lis	or complications that ca t only one cause on eac	aused the death th line.	. Do not ente	r the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician/ Medical	(5 )	Immediate Cause (Final disease or condition resulting in death)	a. SARCO	MA or as a conseque	ence of):					Offset and Death
	Examiner	er	Sequentially list conditions,	b. Due to o	or as a consequ	ence of:					
11.	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or iinjury that initiated events	С	1100-1-0-1						
66 h	be executed /sician and e burial-transi	edical E	resulting in death) Last	Due to (d	or as a consequ	ence of):					
Box 6876		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Fetal	death 3	Ectopic pregnan	ісу		23d. Date of d	elivery Day Year
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	ires that signed Id be de	d by	Part II. Other significant condi	tions contributing to de	ath but not resu	ılting in the u	nderlying cause g	iven in Part I.		tobacco use contribute	to the cause of death?  Probably 4  Unknown
CROWDER Records, P.	law requ has beer e 2 shou	Completed							24a. Was	prior to	utopsy findings available completion of cause of
	an: The tificate tor, pag	Be Cor	25. Was case referred to medic	al			26. F	Place of Death (C			es 2 🗆 No
MARTHA of Vital	Physici this cer al direc	은	examiner? 1 Yes 2 X No  27. Manner of Death	Hospital: 1 🔲 I 28a. Date o	npatient 2	ER/Outpatien	t 3 🗆 DOA			idence 6 X Other (Spe	ecify) HOSPICE
	ttending death. stor: After / the funel	Certificate:	1 X Natural 5 ☐ Pend 2 ☐ Accident Inves	ding (Monti	h, Day, Year)	injury	wor	rk? RYes 2 □ No	28d. Describe	how injury occurred	
Division	spital or Attending Physician; ours after death. earal Director; After this certific filled in by the funeral director,		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	minod 28e. Place	of Injury - At hough	me, farm, stre	eet, factory, office		28f. Location ( City or To	'Street and Number or R wn, State)	tural Route Number,
_	To the Hospital or Attending Physician; The law requires that the within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medica	I Examiner: On the basi	s of examination	and/or invest	igation, in my opin	ion, death occurre	ed at the time, date	ause(s) and manner as s and place, and due to the he cause(s) and manner a	e cause(s) and manner stated.
2	To the withing the comp	2	29b. Signature and title of certif		)		29c. Licens			29d. Date signed (Mor	
			30. Name and address of person	n who completed cause	e of death (Item	23a) (Type. P	K19	19192		1214	wy
			JACKIE JONES,	CRNP 230	O DULAN	EY VAI	LEY RD.	TIMONI	UM, MD 2	1093	
	Sta Registr		31. Date filed (Month, Day, Year	2009 Jen	egistrar's Signa	yar.	Ked				

DECEMBER 12, 2009 4:15 p.m.

			for Amend Item	s State of	Marylan	d, 29epa Cei	rtment o	f Health of Death	and Mentalitis	giene Reg. No. 2	009	40190
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	Day	Year	3. Time of Death
-	/Medic	al	Roland deWit		hari		4h Cib. Tour	n or Legation	Novemb	er 16, 2	2009	10:55 PMM
	Examin	er	4a. Facility Name (If not institution, give 11812 Tifton Da		ber)		Potom	n, or Location 1a.C	or Death		gomer	У
	Funeral		5. Social Security Number 6. So	ex 7	Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ar If Under	24 Hrs. 8. Date of Bi	rth		lace (State or Foreign
	Director			<b>⊠</b> M 2□ F	79 	Yrs.	Worldis	lyo Hould	Feb 28	, 1930	Neth	érlands
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	ctor	MD Montgome:	rу	Poto	mac						1 □Yes 2X No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 11812 Tifton Dr.				10f. Zip Coo 20854			10g. Citizen of USA	What Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Event has must be notified anonce.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? 2 <b>≦</b> No		Was Decedent of Yes, specify C		rigin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rac Bla Specif	ce - Americ ck, White, e whi	etc.
Maryland 21215-0036	ithin 72 ho ne. <b>han "natur</b> Medical	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed) College (1	4or 5+)	(Give life.	dent's Usual Oc kind of work do DO NOT use re	ccupation one during mo tired)	st of working	16b. Kind of B		dustry
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lan(	and be the formal riked o	To Be	Louis Willem de Wi	t					anne Carels		,	
Mary	nd 2 shou alth and N 27 is ma or trauma		19a. Informant's Name/Relationship (1 Gloria de Wit/spou						per or Rural Route Number Potomac,			
Baltimore,	Pages 1 a nent of Hei ant; If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		20b. F	Place of Dispo emetery, cren	sition (Name of natory or other	f place)	Date	20c. Location	- City or To	wn, State
Balt	permit. Departimonts any injury once.		21. Signature of Funeral Service Ucen	iäde, Di	rector			_	Board; 655 yland 21201	W. Balti	lmore	Street
	Dhusisian		23a. Part   Enter the disease, or composition of the composition of th	olications that ca one cause on ea	used the death ch line.				s cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (o	r as a consequence	uence of).	atic.	tol	ung, liver	1 brain		
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):						
8760,	cate be executed ohysician and the burial-transit	dical Exar	that initiated events resulting in death) Last	c	r as a consequ	uence of):						
O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2□Feta ant at time of c	Ideath 3	Ectopic pregn			i i	ate of deliver	ery Day Year
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Divisi	I or Atter after deal Director	Certification:	3 Suicide 6 Could not be determined	28e. Place o	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, factory, offi	ice		(Street and Num own, State)	ber or Run	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C			sis of examina				and place, and due to the eath occurred at the time			
	To th withir To th comp	Me	29b. Signature and title of certifier		-		Į.	cense number		29d. Date sign		
			· WH	WA			MD	D006	3005D	11-19-1	09	
	40		30. Name and address of person who	completed cause		n 23a) (Type, 559 \	Print)	3912	Purard	Dr K	Cock	vule mo
	Sta	te	31. Date filed (Month, Day, Year)	11	gistrar's Signa		· ) ) '	2 , 0	0. 0-	- , ,		· · · · · · · · · · · · · · · · · · ·
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear December 10:32 PM 2009 Jessie R. Englund 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death DINAL HOSPITAL SAltImore 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs Date of Birth (Month, Day, Year) 1□M 2√2F Months Davs Hours 95 1914 073-38-5787 Jan. 16, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 ☐ No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 830 West 40th Street 21211 U.S.A. Apt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐Yes 2 X No Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie McEwan Henry Hunt Romer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21210 205 Hawthorn Rd., Baltimore, William A. Englund (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/9/09 4 Dopation 5 ☐ Other (Specify) Alexandria, VA 21. Sign Jure of Huneral Service Cery ee ^{22. Name and Address of Facility} Capitol Funeral Service 7211 Lee Highway, Falls Church, VA 22046 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): FEMORAL NECK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heart Failure 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Hroni 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury
(Month, Day, Year)

13 1 1 09

28b. Time of Injury
Injury
10 05 PM

1 E

28c. Injury
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending FALL 1 ☐ Yes 2 ☑ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 830 40th 5+. 21211 determined 4 Homicide HOME

**Examiner** law requires that the death certificate be executed and the burial-tran P.O. Box 68760. physician use as Division of Vital Records, page 2 certificate funeral director, or Attending

**Physician** 

**Examiner** 

Director

Funeral

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Completed

Be

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Physician/Medical Examiner

Completed by

Be

Medical Certification: To

(Check only one)

31. Date filed (Month, Day,

1

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm in the marker must be notified at

al Hygiene.

should be filed within 72 hours after

Pages 1 and 2

ţ,

Baltimore,

Department of Heal Important: If item 2 any injury or other

**Physician** 

/Medical

/Medical

within 24 hours after death.

To the Funeral Director: A filled in by the completely

Registrar

29b. Signature and title of certifier 29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khunkhun

Jest Belvedere Ave. Baltimore MD ZIZIS 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, after death

filled in by the funeral director, page 2 To the Hospital or Attending Physician: Certification: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-08-2009 J 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Pishdad, MD 1328 Southern Ave. S.E. Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janice M. Edwards Ecember 2009 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death loc 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖫 F (Month, Day, Year) 214-64-8008 56 Director 0 - 02 - 1953Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director or items 23a or 28a-f 1 X Yes 2 No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 2504 Roslyn Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1X Never Married 2 ☐ Married Completed by 1 Yes 24 No African-American Specify: "natural", 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Balto.city Commission on Agir Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Wright Edwards Mary Edwards .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Roslyn Avenue, Baltimore, MD 21216 Shena T. Allen/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mamorial Park 20c. Location - City or Town, State Important: If i 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 12-19-09 Arbutus, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie funeral Home P.A. of Balto. Co. RNOON 9200 Liberty Road, Randallstown, MD 21133 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anoxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury mgestire for use as the burial-tranattending physician and that initiated events Due to as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 1 Yes 2 9 Unknown been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown diabetes 24b. Were autopsy findings available 24a. Was an has I prior to completion of death?

1 Yes 2 No autopsy After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 11/0 မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Naturai injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 2009 pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrars Signature State

Registrar

atest Krown

			For State Registrar	State of Ma	ryland /	Department o		nd Mental Hy	giene Reg. No. 2	009	4019
404	Physici: /Medic		1. Decedents Name (First, Middle, L	EA-DDY				2. Date of De Month	eath Day	2009	3. Time of Death 6: \$\mathcal{SPM}\$
	Examin Funeral Director		4a. Facility Name (If not institution, g Seasons Hospice 5. Social Security Number 218-52-4832	3	(In yrs. last t	Randa		Death	4c. Coul Bā	nty of Death	ace (State or Foreign
		tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltim	ore	10c. City, To	wn or Location cerstown		3/ 31/	1740		od. Inside City Limits 1 □Yes 2 ☒ No
	th with	ral Director	10e. Street and Number 108 Hammershire		110 101	10f. Zip Coo 211			10g. Citizen o	of What Count	ry?
980	urs after dea al", or items	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 X N If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify 0	Cuban, Mexican,	in? (Specify Ye's or N Puerto Rican, etc.)	E	Race - America Black, White, e cify: $$ B $$ 1 $$ 3	tc.
Maryland 21215-0036	within ene. <b>than</b> "	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5-	+)	6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re Homemaker	ne durina most o	of working		Business/Ind	ustry
land 2	be filed ntal Hyg id other event,	To Be Co	17. Father's Name (First, Middle, Las Edward	st)		Oliver	18. Mother's	s Name <i>(First, Middle</i>	1		Janey
	1 and 2 sho Health and em 27 Is m ther traum		19a. Informant's Name/Relationship Betty Oliver/ S  20a. Method of Disposition			9b. Mailing Address (Str 108 Hammers of Disposition (Name of	shire Ro		erstown		1136
Baltimore,	Pages ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec	ify)	ceme	ny Gifts Regis	try 12	2/16/2009 Anatomy G	Hanove	er, Mar	yland
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€8760, ₩	tificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequenc	e of):					
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Division	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funera		3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of Inju- building, etc	(Specify)	farm, street, factory, offi		City or To	own, State)		l Route Number,
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				O completed cause of de		a) (Type, Print)	04337		12/	13/20	009
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	Registr	वा	7170 21	mana Ario	1						

DHMH 17 Rev 1/2001

09-09750 George Elder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	an/	For State Registrar 1. Decedent's Name (First, Middle GEORGE REUBEN ELL		Cen	ificate of	Death		2. Date of Dea	og. 140.	ar	Time of Death 0959 hrs
Exami		4a. Facility Name (if not institution 3900 N. Charles Street	, give street and numb	er)	4	b. City, Town, or Baltimore	Location of Dea		4c. County		
ineral rector		212 20 0007	5. Sex 7.	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bin. MArch 2		9. Birthpl Countr	ace (State or Foreig y) O <b>rK</b>
w any	ŀ	Usual Residence of Decedent  10a. State  10b. County			Town or Location	on					d. Inside City Limits
or items 23a or 28a-f show must be notified at once.	Director	Maryland None  10e. Street and Number  3900 North Charles	Street #201	Rai	timore	10f. Zip Code 21218	_	1	10g. Citizen of W		<b>AA</b>
, or items 23s r must be not	Funeral	11. Marital Status 1 Never Married 2 XXMar 3 Widowed 4 Divo	12. Was Deced Armed Force 1XX Yes rced If Yes, Give Year		I If Ye	Decedent of Hises, specify Cuban	, Mexican, Pue	Specify Yes or No rto Rican, etc.)		te, etc.	Indian, Black,
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	or Dates:		16a. Decedent during mo	's Usual Occupation of working life	ion (Give kind o		16b. Kind of B	usiness/Indu	ustry
ental Hygiene irked other the rent, the Med	Be	17. Father's Name (First, Middle, I George Reuben Elder	Last)		vice r	resident		me (First, Middle, Gertrude C	Maiden Surnam		
Ith and Me n 27 is ma numatic ev	7	19a. Informant's Name/Relationsh Hazel Key Elder		life	3900 N	orth Charl	es Stree	t #201 Bal	timore, Ma	aryland	21218
ment of Hea tant: If iter or other tra		20a. Method of Disposition  1 Purial 2 XX Cremation  4 Donation 5 Other Spe	ecify:	State CI	rematory or oth	rematory	Dec	Date C 18,2009	Baltimon	re, Mar	yland
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ysician and burial - transit	Medical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate course. Enter Underlying Course (Disease or injury that initiated events resulting in death) Last  UNPENDED	Due to (or as a co	onsequence of	):						
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ficate has been signed by the attending phy. page 2 should be detached for use as the b	by Physician	1 Yes 2 No 9 Unk	nown 9 Unknow	n		inderlying cause		1 Ye	s an ppsy formed?	3 Probat	osy findings availab
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death. ctor: After this certificate has been signed by the attending phy. y the funeral director, page 2 should be detached for use as the b	Be Completed by	Part II. Other significant condition  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 ✓ Natural 5 Pend	Hospital: 1 Ing	n leath but not re	ER/Outpatient 28b. Time of i	26.Place 3 DOA njury 28c. Inju	e of Death (Che Other ₄ Nu Iny at Work? Yes 2 No	1 Ye 24a. Wa: auto perf 1 Yes eck only one) rsing Home 5 28d. Describe	s an ppsy ormed? 2 No Residence 6 Phow injury occur	Probata  Were autor prior to condeath?  Yes  Other: Surred	osy findings availab popelation of cause of 2 No
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					rtment of Health and	Mental Hy	giene	
			State Registrar	Cert	ificate of Death		Reg. No. 2 0 0 9	40196
	Physicia /Medic		Decedent's Name (First, Middle, Last)     LìSa	Fo	wikes	2. Date of Dea Month Decembe	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dear	th	4c. County of Death	$\wedge$
	Funoral	-	The Johns Hopkins Hospital  5. Social Security Number   6. Sex   7. Age	e (In yrs. last birthday)	Baltimore City  If Under 1 Year If Under 24 Hrs	8. Date of Birt	th 9. Birthr	place (State or Foreign
	Funeral Director		219-96-7984 10M 2KF	47 Yrs.	Months Days Hours Min	Augusi	+24 1962 Nai	riland
	and ow		Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Loc	eation	J	,	10d. Inside City Limits
	Maryl a-f she iied at	tor	MD NA	Pa	1timore			1 Yes 2 □ No
	or 28.	Director	10e. Street and Number		10f. Zip-Code		10g. Citizen of What Coun	try?
	eath w		22 8 E. Oli Ver	Street	21213		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydjene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Earned Forces?  1 Yes 2 If Yes, Give		Vas Decedent of Hispanic Origin? (See, specify Cuban, Mexican, Puer	specify tes of No- to Rican, etc.)	14. Race - Americ Black, White, (	etc.
5-0 -0	72 ho 'natura Jical E	eted	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation sind of work done during most of we	orking	16b. Kind of Business/In-	dustry
121	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+) Food	Science (	veleo D	Thos Ha	OKIR
<u>0</u>	e filed with Hygiene other than ent, the N	Be Co	17. Father's Name (First, Middle, Last)	. 1.000	18. Mother's Na	ame (First, Middle	, Maiden Surname)	14.03
ylar	Menta Menta arked artic ev	To E	Willie Lee Towlk	es	Milo	lveck	Cousins	7 الم
Maryland	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print) Wendell R. Fowlkes	19b. Mailing	g Address (Street and Number or F	Rural Route Numb	er, City or Town, State, Zip	Code)
	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	Date Date	20c. Location - City or To	wn, State
Itimore,	Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	Gardens	atory or other place)  Tark 12	21/091	Baltimo	re, MD
a	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee		Name and Address of Facility	swell	Fuxeral	Home
8	0 0 5 5 0		23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	331 Brehms L	-n, B		AD 2/2/3 Approximate
	Dhunisian		shock, or heart failure. List only one cause on each line	e.	, •	ac or respiratory a	ilest,	Interval Between Onset and Death
,	Physician /Medical			Respirator a consequence of):	ry Infection			
	Examiner	_	Sequentially list conditions, b.					
	ed sit	Examiner	if any, leading to immediate Due to (or as a cause. Enter underlying Cause (Disease or injury	a consequence of):				
•	execut and ial-trar		that initiated events C.	a consequence of):				
8760	icate be executed physician and sthe burial-transition	edical	d					
9	ertifica ing <b>p</b> h		IF FEMALE:					
Box	leath certific attending pl	Physician/M	in the past 12 months:	2 Fetal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
o.	the d	hys	1   Yes 2   No 9   Unknown 9   Unknown					
Division of Vital Records, P.O.	The law requires that the death certificate be executed to have been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but	ut not resulting in the ur	nderlying cause given in Part I.		obacco use contribute to the	- 4
Örd	requir een si should	Completed				1 1		-
Re	has b	dmc					prior to co rmed? death?	psy findings available impletion of cause of
		Be Co	25. Was case referred to medical		26. Place of De	1 ☐ Yes ath (Check only or		2 No
>	hysicii iis cert il direc	전 B	examiner? 1 [] Yes 2 X No Hospital: 1 Inpatier		3 DOA Other: 4 Nursing I	Home 5 Resid	dence 6  Other (Specify	/)
E E	iing PI	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day)		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe I	how injury occurred	
/isi	Attend death ctor: / cty the	Certification:		ry - At home, farm, stree		28f. Location (	Street and Number or Rura	al Route Number,
ā	al or A s after if Dire	Certi	4 ☐ Homicide determined building, etc	. (Specify)		City or Tow	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death or the Funeral Director. After this certifica completely filled in by the funeral director,	edical (	29a. Certifier (check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or inve	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as s date and place, and due t	stated. to the cause(s)
	<b>То the</b> within <b>То the</b> сотр	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month,	Day, Year)
			More Rusinasurany		RES-000		pecember 16,	2009
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F		North Mr-	Ifo St. Boltima	o MD 21207
	Sta	te	31. Date filed (Month Day Year) 2009 32. Registrar	r's Signature,		NORTH WO	olfe St, Baltimor	e, IVID, 2128/
	Registr	ar	UEL 17 2009 June	w B. Do	sepher			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar C6	rtificate of Death	Reg. No. O O O O O
	Diversiale	. ,	1. Decedent's Name (First, Middle, Last)	2. Date of De	
	Physicia Medic		Robinlee Ann Ferreri	Month	Day ZOUG OSIOLM
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
للمر براسده			Howard County General Hospital  [5. Social Security Number   6. Sex   17. Age (In yrs. last birthday)	Columbia  If Under 1 Year If Under 24 Hrs. 8. Date of Bir	Howard
	Funeral Director		549-37-3586  Usual Residence of Decedent		th 9. Birthplace (State or Foreign Country) 1961 Connecticut
	ould be filed within 72 hours after death with the Maryland tod Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ţ		ocation	10d. Inside City Limits
	Mary 28a-f otifie	Funeral Director	MD. Howard Ellicott	City	1 ☐ Yes 2 🕅 No
	h the	ai D	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th wit ns 23 must	ner	8413 Mitzy Lane	21043	United States
	r dea or ite			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
3	s afte ral", c	q pe	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates,	1 ☐ Yes 2 📉 No Specify:	Specify: White
ဂ ဂ	natu dical	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business Industry
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12) College (1-4 or 5+)	OO NOT use retired)	
ק ס	ed wii Hygie other ent, th	Be		naker  18. Mother's Name (First, Middle,	At Home  Maiden Surgeme)
a	be fill lental rked tic ev	욘			ones
a S	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)
	1 and 2 should be if Health and Men item 27 is marke other traumatic			Mitzy Lane, Ellicott Cit	
Baltimore,	ge 1 a nt of H : If ite or oth	1		matory or other place)	20c. Location - City or Town, State
	permit. Page Department Important: I any injury or			Crematory Dec. 11,2009	Glen Burnie, Maryland
Ra	permit. Page 1: Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	2. Name and Address of Facility AMPROSE FO 328 Sulphur Spring Road, A	arbutus, MD. 21227
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		
	Pnysician		Immediate Cause (Final disease or condition	Shock	Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a lonsequence of):	1. 4	a.l.i.
ı		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence oi).	/1/4	29 h/s
þ	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury		
)	exect an an rial-tra	EX	that initiated events resulting in death) Last  C		
8/60	rificate be executed ing physician and s as the burial-transit	Medical	d		
200	ertifica ding p				
X R Q	death c he atten ed for u	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
	the de by the ached	hys	9 Unknown		
J.	v requires that the death cer t been signed by the attendi should be detached for use	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
S	law requires nas been sign 2 should be	Completed by	C14 174 JE1917		es 2 □ No 3 □ Probably 4 □ Unknown
ō Ç	law n has b e 2 sh	mple		24a. Was	psy prior to completion of cause of
ř	r: The licate r, pag			1 ☐ Yes	
Division of Vital Records,	sicial certii irecto	o Be		26. Place of Death (Check only one)	
5	g Phy er this eral d	e: To	1 Empation 2 Envoupage	of 28c. Injury at 28d. Describe	dence 6 LI Other (Specify) how injury occurred
o	endin eath. or; Aft	ficat	12 Natural 5 Pending (Month, Day, Year) injury	M 1 ☐ Yes 2 ☐ No	
NISI	or Atte fter de irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
5	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2			occured at the time, date and place, and due to the co	pure(e) and manner as stated
	e Hos n 24 h e Fun eleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	stigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated. I
	Vithin Vithin Corrig		29b. Signature and title of ceptilier	29c. License number	29d. Date signed (Month, Day, Year)
			MAL	1946120	Dec. 10, 2009
	\		30. Name and address of person who completed cause of death (Item 23a) (Type,	Rittle Potofent PK	Dec. 10, 2009 by Cohumbia, MS 24
	Sto		31. Date (Her Morris, Pr. Year) 32. Registrack Signature	DILLIC IGITIFAL PA	wy COLUMBIA, MD
	Stat	.e	UEL A 1 6003 Control of the Control		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1207 AM Robert Andrew Flury December 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St Agnes Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6/28/1930 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min. 1X□ M 2□ F 79 Director 213-26-8397 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Exactions runt be multiped at 1 Yes 2 No Director Maryland N/A <u>Baltimore</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 524 N. Charles St. 21201 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes XX No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Tires <u>Sales</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Anna (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If Item 27 is any injury or other trauonce. Andrew Flury (Son) 3501 Davenport Ct., Apt. Pasandena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 12/17/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part I then the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Sepsis Days/Hours **Physician** /Medical Due to (or as a consequence of): Examiner Infarcted Stomac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Smoking Hypertension 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Hyper lipidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ※ No 24a. Was an icate has t ; page 2 s autopsy Atrial Fibrillation 2 No -lury, Rober Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🔏 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State

29b. Signature and title obsertifier

Nisham

Registrar

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death <del>U U S</del> 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ H0 Year 05/1 M MC 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Davs Hours Min. (Month, Day, Year) 11V 17. 1911 Country) Onio 98 Director 216-44-9350 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🌠 No Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Shipwright Harbor 21401 USA Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 19 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1935 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 1946 Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Navel Academy 4 Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Derr Oscar Gillmer Hazel Voit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 Watermans Way Reedville, VA 22539 Charles Gillmer, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕅 Cremation 3 🗀 Removal from State any injury or Metro Crematory Inc. 12/17/09 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Thomas Pame and Address of Facility Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been signed director, page 2 should be def þ Hospital or Attending Physician: The law requires 2 No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 \( \text{Yes} Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA AICE this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at HOUSE 28d. Describe how injury occurred 5  $\square$  Pending work? Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN APOUS M DZ140/ EFENSE HIGH WAS ICHARL ENTA un 445

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31 Ther DVR 8898 12/1/109111 Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ DOROTHY 11:35AM GOVG15 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death
B9 (HMORE Examiner Road Baltimore Digla 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🗶 F Months Hours 099th Day Country) 81 **Director** Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6920 Diabi Road 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Was Deceding Armed Forces?

1 Yes 2 No 14. Race - American Indian. 0. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: Black 3 X Widowed 4 □ Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County College (1-4 or 5+) Elementary/Seconday (0-12) 12th arade Teacher Schools ubstitute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alonzo Overton Dorothy Fallin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hobart Court Randall stown MD 21133 Winifred Jones 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 118/09 Baltimore, MD 4 Donation 5 Other (Specify) Youghn C. Greene Fureral services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown Mb 21133 28 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LECTROLYTE IM BALANCE Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 12/2 Medical Due to (or as a consequence of): Examiner PIARRHEA CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Exami burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by PROCTITIS RADIATION cate has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop. performed 2 DIMBETES MECCITUS After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title or certifier 29c. License number 2009 D-43417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWATI DESAL MEHOE MD 20755 n. KACC, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4020 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Calvin Norwood Gilbert 2009 12:45 P™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Locust Lodge Pasadena Anne Arundel 5. Social Security Number Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours 1 XM 2 □ F Director 212-30-8355 76 or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗆 Yes 2 🕅 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 184 Meadow Road United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing <u>Buyer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Gilbert Edith Jessop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Gilbert - Son 1904 Nobles Mill Road, Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/14/2009 | Glen Burnie, MD Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or compile then sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on east, line Interval Between Onset and Death Immediate Cause (Final Physician/ hermer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 🗌 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 1 42820

btl

30. Name and address

31. Date filed (Month, Day, Ye

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

Registrar

m.1)

Road

3708 mountain

son who completed cause of death (Item 23a) (Type, Print)

cBoria

32. Registrar

		_ For	Stat	te of Ma	rylanc	d / Depa	rtment of F	lealth and	Mental Hy	s Ar gien	e Legic	9	40202
		State Registrar				Cer	tificate of L	Death		Reg. N			40202
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Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 □		(In yrs. las		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth av. Year	9	. Birthpla	ace (State or Foreign
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12 should an alth an 27 is rutau		Deborah J. Gr		ughter	:		g Address (Street a						
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permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signatury of Fugural Serv	May			Mc	Name and Addres Comas Fu 317 Cokes	s of Facility neral H bury Ro	ome, P.A ad, Abir	igdor	n, Mar	vlan	d 21009
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ending r use a	an/	IF FEMALE: 23b. Was decedent pregnant		s, outcome of Live Birth 2			Ectopic pregnanc	v			23d. Date o	f deliver	у
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aw rec as bec 2 sho	Completed								24a. Was				y findings available pletion of cause of
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tal or At rs after o al Direct ed in by	Cert		termined 28e. F	Place of Injury puilding, etc.		e, farm, stre	et, factory, office		28f. Location ( City or To			r Rural R	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Media	ying Physician: To f cal Examiner: On the ying Nurse Practio	e basis of exa	amination a	and/or investi	gation, in my opinio	n, death occurred	at the time, date	and plac	e, and due to	the caus	e(s) and manner stated.
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axl	4	30. Name and address of per	son who completed	cause of dea	ath (Item 2	(3a) (Type, Pr	in ble 4:	11 (-	, <u>(</u> )				21093
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Amend #25 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25 Per ME 9901 3/19/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year Physician Elem Der 15, 2009 5:26A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Sept. 12, Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 78 Texas 459-40-3296 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 28a-f show at 1 X Yes 2 □ No **Funeral Director** Examiner must be notified Corpus Christi Texas Nueces 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ò 78412 U.S.A. 23a 4734 Ocean Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 b 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other than Education University Professor the 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alta Lorine Hardy James Oscar Hedrick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 1172 Corpus Christi, TX 78403 t of Health Joe C. Hedrick (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or o once. 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metropolitan Crematory 12/16/09 Alexandria, VA 5 Other (Specify) 4 Donation 2. Name and Address of Facility Maxwell P. Dunne Funeral 1222 Morgan Ave., Corpus 21. Sign nure of Funeral Service Livense Home Christi TX 78404 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardio pulm disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** mon stom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dissilto for as a consecuence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events CERTIFICATION Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 200 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: Inpatient 3 □ DOA 2 ER/Outpatient Medical Certification: To within 24 hours after death.

To the Funeral Director: After this and annietely filled in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death atural 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 255000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2009 lecEm ho /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Home MONTGOMER AND NURSING S(48672 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6/2-7) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 🗷 M 2 🗆 F 139-40-0247 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 DXYes 2 □ No Director 40 10e. Street and Number 10g. Citizen of What Country? LINCOLN STREE Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: BLACIC 21215-0036 1 ☐ Yes 2 🗷 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOTO GRAPHER 12 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental HERBERT COREIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RISCILLA Important: If item 27 any injury or other tr HERBERT-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEM COM 12-12-09 LANDONER, IND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 10220 GUILFORDRY JUSSED, MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDID /Medical Due to (or as a consequence of): Examiner SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) HRONIC Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown ۳. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No Vital 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ot 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225, SHADY GROYF R.D. ROCKVILLE, M.D. 1.1.D. 32. Regierrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year HEATH **Physician** ENIT 01 ECEMBER 13 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RANDALLSTOWN THWEST HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Hours | Min. | 20 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF Months 785652 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County r than "natural", or items 23a or 28a-f sho the Medical Experies must be rotified at 1 ☐ Yes 2 No Director MD Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 8 Wincrest Court 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married specify: African-American 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 11 a 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental thygien Important: If Item 27 is marked other the any Injury or other traumatic event, their once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>John Harris</u> Janice Heath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice Heath/Mother <u> 8 Wincrest Court, Pikesville, MD 21208</u> 20c. Location - City or Town, State 20a. Method of Disposition Fintament 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 12-19-09 Pikesville, MD 22. Name and Address of Facility Wile fineral time P.A. of Parto. Co. 21. Signal re of Funeral Service Licensee randon 9200 Liberty Road, Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IMMUNE DEFICIONO SNNDROME Physician ACQUIRED /Medical Due to (or as a consequence of): Examiner YEARS IMMUNODEFICIENCY VIRUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DEPRESSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

e Funeral Director: After this certificate has t letely filled in by the funeral director, page 2 s autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune completely f (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ပ္ DECEMBER 13, 2000 KIND ATTENDING PHYSICIAN RANDALLSTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUZTHWEST HOSPITAL CENTER 5401 OLD COVET ROAD MARYLAND 21133 ADEYIGA OLADUNNI

DHMH 17 Bev 1/2001

State

Registrar

31. Date filed (Month, Day,

1

32. Registra Signa

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 15 1:10 AM Cameron Trent Harper 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) DALTIMORE CT HONES HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 → M 2 □ F Maryland 51 Dec. 8, 1958 216-78-8278 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No N/A Maryland **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21229 4213 Rokeby Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates 1 □Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rock Quarry Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robertson Lorraine William Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Rokeby Road, Baltimore, Maryland 21229 William Harper/ Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 15. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facilit MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Amanda Heaston 301 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death ENCEMALOPATAY ANDXIC Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): HYAO GLYCEMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown

Examiner Hospital or Attending Physician: The law equires that the death certificate be execute attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, ned by the ertificate has been signed ctor, page 2 sf-ould be det n 24 hours after death.

Funeral Director: A pletely filled in by the fu To the Hosp within 24 hor To the Fune completely fi

CAMPEROR

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Medical Certification: To

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a filed Examinating the conflict at once.

**Physician** 

* /Medical

Baltimore, Maryland 21215-0036

the Maryland

Part II. Other significant conditions	s contributing to death but not res	sulting in the underlying	g cause given in Part I.			ntribute to the cause of death?  3 Probably 4 Unknow
payortensin all	use			per	s an 24b. opsy formed?	. Were autopsy findings availab prior to completion of cause o death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	Othor	ath <i>(Check only</i> Home 5 ☐ Re	one) sidence 6 □Ot	ther (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury occu	rred
3 ☐ Suicide 6 ☐ Could not determine		ome, farm, street, factory)	ory, office	28f. Location City or To	(Street and Nuп own, State)	ber or Rural Route Number,
	Physician: To the best of my know caminer: On the basis of examination and manner stated.					
29b. Signature and title of certifier	14.	- 1	29c. License number		29d. Date sign	ed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

			State	Department of Health and I Certificate of Death		2009 40207
		b	Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	
	Physicia Medic		Sylvia Hayden			Year 4, 2009 11:20P ^M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
~ ·			Stella Maris Hospice  5. Social Security Number	Timonium  If Under 1 Year I If Under 24 Hrs.		Baltimore
	Funeral Director		1 DM 2 20 5	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 2/9/1957	9. Birthplace (State or Foreign Country) France
	d ow t		Usual Residence of Decedent		2/ 5/ 1551	
	aryland a-f sh iled a	Director	10a. State 10b. County 10c. City, Town			10d. Inside City Limits
	he Ma or 28a on 24a		MD Balimore Phoeni	X 10f. Zip Code	10g Citi	1 ☐ Yes 2 🔀 No izen of What Country?
	with t	Funeral	2527 Paper Mill Road	21131		J.S.A.
	items		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	after Il", or xamir	Be Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 🛛 No Specify:		Black, White, etc.
21215-0036	hours natura ical E	lete	15. Decedent's Education 16a.	Decedent's Usual Occupation		md of Business Industry
215	in 72 e. han "r	duc	(Specify only highest grade completed)	(Give kind of work done during most of worl life. DO NOT use retired)	sing 166. Kill	nd of Business industry
7	d with lygien ther ti	Č Č		armacy Technician		rmacy/ Retail
Maryland	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last)  Michel	Malherbe   Jacquel	e (First, Middle, Maiden S ine	Surname) Maquet
ary	hould ind Me s mar umati			Mailing Address (Street and Number or Run		
Σ	nd 2 sl ealth a n 27 i			527 Paper Mill Road,		
Baltimore,	ge 1 and tof Hitch			Disposition (Name of y, crematory or other place)	Date 20c. Loc	cation - City or Town, State
<u>ti</u>	uit. Pagartmer artmer ortant njury					over, Maryland
Ba	Depar Impor any Ir		21. Signature of Puneral Service Acensee	22. Name and Address of Facility An 7522 Connelley Dr		
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. BREAST CANCER			Onset and Death
	Examiner		Due to (or as a consequence of	f):		
		iner	Sequentially list conditions, if any, leading to immediate	f):		
	cuted and transit	Examiner	Cause (Disease or impury that initiated events c.			
_	cate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of	η.		
3760	ficate g phys	00 1	d			
Box 687	n certii ending r use a	sician/M	F FEMALE: 23b. Was decedent pregnant   in the past 12 months?   23c. If yes, outcome of pregnancy   1	3 ☐ Ectopic pregnancy	2	23d. Date of delivery
Bo	e deatl the att hed fo	ysici	in the past 12 months?  1 ☐ Yes 2 X No 9 ☐ Unknown  In the past 12 months?  4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day Year
P.O.	hat the ed by detacl	y Phys	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
S,	uires t n sign lid be	ed by			1 🗆 Yes 2 🕽	No 3 ☐ Probably 4 ☐ Unknown
Sor	as bee 2 shou	Completed			24a. Was an	24b. Were autopsy findings available
Rec	The la	Com			autopsy performed? 1 \(\sum \) Yes 2 \(\fomathbf{X}\) No	prior to completion of cause of death? 1 ☐ Yes 2 🛣 No
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec		
>	Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 <b>X</b> No 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti	- Transmig in	ome 5 Residence 6	
on C	nding ath. r: After e fune	icate		jury work?  M 1 \( \text{Yes} \ 2 \( \text{No} \)	28d. Describe how injury	occurred
Division of Vital Records,	r Atte ter dea rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office		Number or Rural Route Number,
á	oital o				City or Town, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check check only one)  1 ☐ Certifying Physician: To the best of my knowledge, do check only one)  3 ★ Certifying Nurse Practioner: To the best of my knowledge.	investigation, in my opinion, death occurred a	t the time, date and place :	and due to the cause(s) and manner stated
	Vithi Vithi To th		29b. Signature and title of pertifier	29c. License number		e signed (Month, Day, Year)
			- JANUSLANP	13149792	12	15/2009
			30. Name and address of person who completed cause of death (Item 23a) (T			
	Stat	e	JACKTE JONES, CRNP 2300 DULANEY  31. Date filed (Month, Day, Year)  32. registrar's Signature	VALLEY RD. TIMONIUM	1, MD 21093	
	Registra		OEC 17 2009 Some B.	fare		

DECEMBER 14, 2009 11:20 p.m.

SYLVIE HAYDEN

			For State Registrar	State of Marylan	-	rtment of H <i>tificate of L</i>			giene _{Reg. No.} 2	1.0208
giá	0.00		Hegistrar  1. Decedent's Name (First, Middle, Las	st)		- Intouto of E	Journ	2. Date of De	ath	3. Time of Death
	Physici /Medic		WILLIAM MILTO	N HERREN				Month	Day Year	3.30PM
4	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
			Good Samaritan Ho				imore			
п	Funeral		5. Social Security Number 6. S	MM 2DE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Apr. 2	y, Year)   C	rthplace (State or Foreign country)
	Director		284-24-5722 Usual Residence of Decedent	78				Apr. 2	.7, 1931 OII	10
	yland now at		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	e Mar la-f sl	cto	Maryland Harford	Be.	l Air					1 □ Yes 2 ŽÍNo
	ith th or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	s 23a	era	201 D Fairwood	12. Was Decedent Ever in U	19 112 1	2101		acity Ves or No	USA 14. Race - Am	erican Indian.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	ite, etc.
215-0036	hour Itural	Completed by	15. Decedent's Ed		16a. Deced	lent's Usual Occup	ation		16b. Kind of Busines	White s/Industry
15	in 72 n "na Medic	plet	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of work ()	ing		,
212	d with giene er tha	E O	Elementary/Secondary (0-12)	College (1-401 54)	Sales	Manager			Metal Man	ufacturer
nd	12 should be filed within h and Mental Hygiene. f is marked other than ' rraumatic event, <u>the Me</u>	Be (	17. Father's Name (First, Middle, Last)	)				•	, Maiden Surname)	
yla	ould I Men narke	유	William (unk) H		1		Kelley M			7. 0
Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship ( Patrick Snyder			•			er, City or Town, State,	
	1 and 2 Health tem 27 i		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	;	Date	20c. Location - City of	
Baltimore,	pernit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		1 ☐ Burial 2 XI Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemoval from State	•	natory or other plac	orp. 12-2	2_00	Towson, Ma	ryl and
a‡:	permit. Page Department of Important: If any Injury or once.		21. Sign fune of uneral Service Liver	nsee"	11 COD 8	Name and Addre	ss of Facility uneral Ho	me D Z		LYLAIM
ä	Depar Impor any Ir	1 7)	Mallella	my					ngdon, MD 2	1009
п		3	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Henorhayis	Shed	cseun	dary to	Urerr	acutrointe	b .
	/Medical Examiner		resulting in death)	a. Due to (or as a conse			- S	8		
		<u>~</u>	Sequentially list conditions	b. Due to (or as a conse	quence of):	sensolar	y to co	aguly ou	ably	
A -	uted 1 ansit	Examiner	Sequentially list conflictions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that battled as post-	ì						
)°	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
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-	ertifica ing ph e as th	Med	IF FEMALE:							
Вох	The law requires that the death certific the has been signed by the attending Forge 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1☐Live birth 2☐Fet	tal death 3	Ectopic pregnanc	у		23d. Date of o	delivery Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5L	Other (specify) _				
P.0	that t ed by detac	, Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Records,	quires n sign ald be	d b	Auto polana	m Edona				10	Yes 2 No 3□	Probably 4 □Unknown
S	s beel	lete	As also to	ob comic R	coal fo	ilure		24a. Was		autopsy findings available
æ	The lav	m o	Obol ball	- L 'L 0	\		1 = = = = = = = = = = = = = = = = = = =	auto perf 1□ Yes	ormed2 pnort ormed2 death 2√ZNo 1 ☐ Y	
Vital	certificate ector, pag	Be C	25. Was case referred to medical examiner?	no with ka	JOHN MEN	-mula	26. Place of Deal			
or V	Physician: this certifical	To E	1 Yes 2√ No		☐ ER/Outpatie	II 3 DOA	er: 4 Nursing H		idence 6 □Other (S	pecify)
n	ng inel	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	rk?	28d. Describe	how injury occurred	
Sign	Attending r death. ector; After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	De Diago of injury At I	home farm st		Yes 2□No	28f Location	(Street and Number or	Rural Route Number
Division	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)	001, 1401013, 011100		City or To	own, State)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	icalC	(Check only 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examin	nowledge, deal	h occurred at the ti	me, date and place opinion, death occu	, and due to the	e cause(s) and manner e, date and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
			) I Land	/		R F. I	000		12/15/0	Q
	. ^		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,				11917	
	1,0			nardo mo	Steal	Loura	ra boule	ard B	alhave,"	hp 21239
	St Regist	ate	31. Date filed (Month, Day, Year) <b>DEC 1 7 2009</b>	32. Registrar's Sign	The state of the s					
	3		DEC T LEGGO	hav.	* <b>//</b>					

09-09407 Quirra Igbal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uirra iqbai		I- For State	State of	Maryland /		rtment of tificate of			wenta	al Hygiene	Reg.	No. 20	09	4020
Physicia	n/	Registrar 1. Decedent's Name (Firs	st, Middle,Last)							2. Date of	Death			Time of Death
ledical Examir		Qurra 4a. Facility Name (if not in					qbal		nootion of		nber 3	3, 2009 Year		0730 hrs
		5522 Midwood A					Baltim		ocation of	Death		4c. County of t	Call	
Funeral		5. Social Security Numbe	6. Sex	7. Ag		st birthday)		r 1 Year	If Under	1.0		(MM/DD/YYYY) S	orgian	
Director		216-35-44		2 <b>X</b> F	17	Yrs	Months	Days	Hours	Min. 03	0	2 92	Countr	y) MD
any	ŀ	Usual Residence of Dece 10a. State 10b. 0	County		10c. City,	Town or Locat	ion						100	d. Inside City Limits
	۲	MD	NA			Balt	imor	·e					1	X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number					10f. Zip				10g	. Citizen of What		
ith the 23a or notifie		5522 Midw 11. Marital Status		. Was Decedent	Francia III	2 142 10/6	Decede		212	n? ( Specify Yes	ar No		S.A.	Indian, Black,
leath w	Funeral	1 X Never Married 2		Armed Forces?						Puerto Rican, etc		White, 6		Inglatt, black,
after c	by F	3 Widowed 4	or i	es, Give Year Dates:			Yes 2					Specify:	Bla	
2 hours at "natural	eted	15. Decedent's Education Elementary/Secondary		ghest grade con College (1-4 or s			nt's Usual ( nost of wor			nd of work done se retired)	ľ	16b. Kind of Busir	iess/Indu	stry
5-0036 led within 72 Hygiene. other than '	Comple	11th grad		na	,	U	nemp	loy	ed			Une	nplo	yed
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Eximiner must be notified at once	٥	17. Father's Name (First,				-				Name (First, Mic				
212	lo Be	19a. Informant's Name/Re	Iqba elationship (Type,					(Street	and Numb		e Numb	er, City or Town,		
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I iant: If item 27 is marked or other traumatic event,		Albert Be		-Uncle							, C	levela	nd,	Ohio
ore, MEss 1 and 2 s of Health an If item 27		20a. Method of Disposition  1 X Burial 2 Cr		Removal from Sta	i	Place of Dispos rematory or of			etery,	Date		20c. Location - C	ity or Tov	vn, State
Baltimore, permit. Pages I ar Department of Hee Important: If itel injury or other tr.	1	4 Donation 5 C	Other Specify:	1		arkwo		Addross		12/18/	09	Parkv	<u>ill∈</u>	e, Md
Ba perm Depa Inipu		21. Sistante di Fullerali	d Conse	Shann		Ma  43	rch	F/H Jaba	Wes sh A	t ve, Ba	lti	more,	Md 2	21212
Physician (Markins)	V	23a. Part I. Enter the dise			the death.	Do not enter	he mode o	of dying, s	uch as ca	rdiac or respirato	ry arres	st, shock, or heart	1	Approximate Interval Between Onset and
/Medical xaminer	H	Immediate Cause (Final or condition resulting in o	disease a.Blu	nt Force Inju									-	Death
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60, ate be executed hysician and te burial - transit	Medical	UNPENDED	d	MENDED								<u></u>		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Med	IF FEMALE:	2	3c. If yes, outcor	me of pregr	nancy						23d. Date of d	•	
Box 6876  The death certificat  The attending phed for use as the	Physician/	23b. Was decedent pregn past 12 months?	ant in the	Live birth Pregnant at	time of de		etal death ther (Spe	3 L	Ectopic	pregnancy		Month	Day	Year
BO) ne death the att	hysi	1 Yes 2 No 9	1 2									<u> </u>		
r, P.O.	≦	Part II. Other significant	t conditions cor	tributing to deat	h but not re	esulting in the	underlying	cause gi	ven in Par	1 23e.	_	2 No 3		
cords, law require has been si, 2 should b	Completed										Was a			sy findings available
ecol he law ate has	dwa										autops perform Yes 2	ned? de	ath?	2 No
Vital Rec hysician: The l this certificate b	Be C	25. Was case referred to examiner?	<b>——</b>							Check only one)				
f Vit	ို	1 Yes 2  27. Manner of Death	No Hosp	Ital: 1 Inpatie	ent 2	ER/Outpatien		<u> </u>	Other ₄	Nursing Home	Account .	Residence 6		cene
ion of tending Pheath.	ţi	1 Natural 5	Pending	FOUND: Day,	ear)	FOUND:	injury		es 2 🗸	Subject	struc	k in the head	multip	ole times
Visic or Atte fter dez Directo	ertification:	2 Accident 3 Suicide 6	Investigation Could not be	Dec 3, 2009 28e. Place of Ir	njury - At ho	0600 hrs ome, farm, stre	et, factory	, office bu	uilding, etc		ition (St		or Rural	Route Number, City
Divisi Spital or Att hours after d ueral Direct	S	4 V Homicide	determined	(Specify) ML						5522 Mic	boowb	Avenue Apt. #		nore, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certi	fying Physician: ical Examiner:On	the basis of exa	y knowled mination a	ge, death occu nd/or investiga	irred at the ation, in my	e time, da y opinion,	te and plac death occ	ce, and due to the curred at the time	e cause , date a	e(s) and manner a and place, and du	s stated. e to the c	ause(s)
To with Con	Me	29b. Signature and title of		manner stated.			290	c. License	number			29d. Date signed	(Month	, Day, Year)
	-	DIM	)	,				O.C.N	Л.E.			December 4	, 2009	
3v		30. Name and address of Donna M. Vince		pleted cause of d sistant Medi			1 Penn	Street	Baltimo	ore, MD 2120	1	-		
St	ate	31. Date filed (Month) Da			r's Signa	- 4		J., 00t,						
Regist		، بالمال	- 1	person	1 13	· Janes								

DHMH 17 Rev 1/2001 OCME 2006

			For State	State	of Maryla		artment of H			_ Z U	09	40210		
			Registrar  1. Decedent's Name (First, Middle.)	Lacti	<del>-</del>	Ce	Tillicate of I	Jealii	2. Date of De	Reg. No.		3. Time of Death		
	Physici	an		,					Month	Day	Year			
0	/Medic		Vivian Marie J  4a. Facility Name (If not institution.		umhor)		4h City Town of	Location of Death		er 11, 20		9:00 A ^M		
S	Examin	er	Sun Valley Assi	3	,		Westmin			Carroll				
	Funeral			6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign		
	Director		236-22-4586	1 □ M 2 1 F	87	Yrs.	Months Days	Hours Min.	Oct. 2	5, 1922	Ves	t Virginia		
	P .		Usual Residence of Decedent  10a. State 10b. County		100	City, Town or Lo	ention					0d. Inside City Limits		
	anyla shov	<u>_</u>			100.	City, Town of La	ocation				- '	1 □Yes 2 ☑ No		
	he M 28a-f otifie	Director	MD Freder  10e. Street and Number	ick	l N	ew Marke				10g. Citizen of W	// A O			
	with t	흡		1 5 1			10f. Zip Code				mai Coun	itry ?		
	eath ns 23 must	Funeral	10392 Hedgeapp		cedent Ever i	n U.S. 13.	21774 Was Decedent of H	ispanic Origin? (Sc	necify Yes or No	USA 14. Race	e - Americ	an Indian,		
_	r iten	Ē	1 ☐ Never Married 2 ☐ Marri	Armed F ed 1 ☐ Yes	2 X No		Was Decedent of H If Yes, specify Cuba		o Rican, etc.)	Blac	k, White,			
3	hours after death with the Maryland tural", or items 23a or 28a-f show M Examiner must be notified at	b	3 ₩Widowed 4 Divorced	If Yes, C Year or	aive Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify	: W	Nhite		
ر ک	be filed within 72 hours after death with the Marylar tital Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or officed at event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed	f)	16a. Dece	dent's Usual Occup	king	16b. Kind of Bu	siness/Inc	dustry			
7	filed within 72 Hygiene. other than "na ent, the Medio	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)		_	work done during most of working T use retired)						
7	e filed v al Hygie other t vent, th		I ()  17. Father's Name (First, Middle, I	l ast)		Hom	emaker	18. Mother's Nan	ne (First, Middle	, Maiden Surnam	n Hon	ne		
Maryland 21215-0036	d be i	Be c	Robert E. Burg	*					ie Alba		-			
₹	should be nd Mental marked Imatic ev	မ	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Number or Ru	ıral Boute Numl		State, Zic	Code)		
<u> </u>	nd 2 alth al		Sharon Rutherf	ord-Daug	hter	103 New	92 Hedgea Market.	pple Bene MD 2177	d 4			·		
ē,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic en		20a. Method of Disposition		20	b. Place of Disp	osition (Name of matory or other place in Memoria	ce)	Date	20c. Location -	City or To	own, State		
Ë	Page nent c int: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si		n State   I	ligh Law Park	n Memoria	12-1	4-09	Oak Hil	1. W	V		
Baltimore,	mit. porta porta y Inju		21. Signature of Funeral Service	Licensee	0		2. Name and Addre		yree Fu			999 Jones		
<u>n</u>	8 <b>2 E 8</b>		meny	Sland		A	venue, Oa	k Hill,	West Vi	rginia	2590	1		
		(	23a. Part1. Unter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the o each line.	leath. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death		
	Physician		immediate Cause (Final disease or condition resulting in death)	a.			Demen	12				Xe 2/5		
	/Medical Examiner		resulting in death)	Due to	o (or as a con	sequence of):	V				1	/		
		i.	Sequentially list conditions,	b. — Due t	o (or as a con	sequence of):					-			
0. 5-	uted ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of Ilijury that initiated events		`	. ,								
'n	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	CDue t	o (or as a con	sequence of):								
8760,	te be iysicia ne bu	dical		d								_		
9	ertifica ing ph	0	IF FEMALE:							20 10				
. Box	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome pf pro birth 2 🗌	Fetal death 3	⊒Ectopic pregnanc	/			te of delive	ery Day Year		
	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown											
_	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
Records,	luires sign lid be	d by							1 🗆	Yes 2 No	3 ☐ Prob	oably 4 Unknown		
<u></u>	w requir s been si should t	Completed							24a. Wa	s an 24b.	Were auto	ppsy findings available		
	The law te has age 2:	omp							aute perl 1⊟ Yes	opsy formed2	prior to co death? 1 ∐Yes	mpletion of cause of 2□ No		
Vital	ian: rtifica ttor, p	Be C	25. Was case referred to medical					26. Place of Dea			10103	20110		
	hysic nis ce I direc	To E	examiner? 1 Yes 2 No	Hospital: 1 [	☐ Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	Horne 5□Res	sidence 6 🗆 Oth	er (Specia	fy)		
0	Attending Physician: The sir death. rector After this certificate haby the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☑ Pending		te of Injury onth, Day Yea	28b. Time (	Woi		28d. Describe	how injury occur	redi			
S	ter dleath.	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation	an of initial	At home form		Yes 2 □ No	006 1	(0)		-10-1-11-1		
Jivision or	ō # Ö ⊆	Certification:	4 ☐ Homicide determ	ined 200. Fla	iding, etc. (Sp	pecify)	treet, factory, office			(Street and Numb own, State)	er or Hura	ai Houte Number,		
	Hospital 24 hours Funeral stely filled		29a. Certifier 1 Certifyin	g Physician: To t	he best of my	knowledge, dea	th occurred at the ti	me, date and place	e, and due to the	e cause(s) and ma	anner as s	stated.		
	To the Hospital or Attending Physician: within 24 hours liter death. To the Funeral Director After this certifics completely filled in by the funeral director, it	edical	(Check only 2 Medical one)	Examiner: On the	basis of examendation	mination and/or i	nvestigation, in my	opinion, death occ	urred at the time	e, date and place,	and due t	to the cause(s)		
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	10.6	1.		29c. Licens			29d. Date signe				
•	/			XOVI	1/m	0	100	559943		Decem	sel	11/2009		
	クイ		30. Name and addres of person	who completed ca	use of death	(Item 23a) (Type	, Print)	10 25	1 LESL	Decem	~ ~~	7 21157		
		ate.	31. Date filed (Month, Day, Year)	32 A32	Registrar's S	Signature	W. )	NT 301	VV-)/	MINSTER	1*1.	1-113/		
	Sta Regist	ate rar	DEC 1 7 2000	h	J. A	bark	S							
			LIELS SHUT	ARTH	Ja.	A B								

n Johnson		1- For State	Stat	e of Maryla				and	Menta	l Hygi	iene			0. 0.		
		Registrar	o (Final Adiable I	4\	Cer	tificate of	Death			12	Date of De	Reg. No	. 2 (	00	Time of Death	12
Physicia dical Exami	344	1. Decedent's Name Glen	•		Johr				Month Decembe	Day Year ember 12, 2009			0132 hrs			
		Facility Name (if not institution, give street and number)     Johns Hopkins Bayview Medical Center						4b. City, Town, or Location of Death Baltimore				4	c. County of I	Death		
Funeral		5. Social Security N	lumber 6.	Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under 2	4Hrs. 8	. Date of E	Birth (MN	//DD/YYYY)	9. Birthp	olace (State or I	Foreign
Director		530-29-	4134	X M 2 F	32	Yrs	Months .	Days	Hours	Min.	)4 (	07	77	Coun	AR	
		Usual Residence of													0d. Inside City	Limite
w an		101	10b. County		10c. City,	Town or Locat										
Maryland 28a-f show any d at once.	į	MD NA  10e. Street and Number			Balti	more	000	-			1 X Yes 2 No					
ith the Maryland s 23a or 28a-f shov notified at once.	Director					101. Zip Ci		213		1				, .		
vith th s 23a e notil	ᇹ	3305 Woodstock Ave  11. Marital Status			S. 13. Wa	s Decedent			? (Speci	fv Yes or N	U • S • A •  14. Race - American India			ın Indian, Black	ζ,	
death w	nuer	1 X Never Marrie	ed 2 Marri	ied Armed Fo	orces?		es, specify (						White,	etc.		
after de	by F	3 Widowed		ced If Yes, Give Year or Dates:		T-100-01-1	Yes 2						Specify:		lack_	
hours natur Exam	eted b	111111111111111111111111111111111111111			16a. Deceder during m	nt's Usual Od lost of working						. Kind of Busin				
36 nin 72 i. Ihan "dical"	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade 2yrs			Ιa	borer	•				Pi	egiona rofes	sio	nal		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Compl	17. Father's Name			•	па	DOLEI	18	3.Mother's I	Name (Fi	rst, Middle	, Maide	emp Aden Surname)	gen	с <u>у</u>	
215 be file ntal H rked c	Be	Gregory	Johns	on				1	Myong	gok	Kim					
21, hould bend Mer is mar	입	19a. Informant's Na											City or Town,			
MD alth and 2 sho em 27 is raumati		Gregory 20a. Method of Dis		on-Fath		3305 Place of Dispos					Bal		more,		21213 own. State	<u>}</u>
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygierte. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 <b>X</b> Burial 2		3 Removal fro	om State	crematory or ot	her place)									
it. Par rtmen ortant		4 Donation 5 21. cig at⊌re of Fu			Art	outus	Memor			12/1	9/09	9   1	Arbut	us,	Md	-
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Physician		23a. Fart I. Enter the	e disease, or co	mplications that ca	a se the death	. Do not enter t	he mode of	dying, s	uch as card	diac or re	spiratory a	arrest, s	hock, or hear	t	Approximate I Between Ons	
/Medical Txaminer		Immediate Cause (	Final disease	a. Gunshot W											Death	
		or condition resulting in death)  Due to (or as a consequence of):														
	Je.	Sequentially list conditions,  If any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause														
	Examiner	C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
scuted and transit																
60, te be executed ysician and burial - transit	edical	UNPENDED		AMENDED								1.0	204 Data of 4			
tal Records, P.O. Box 6876i certificate has been signed by the attending phy ector, page 2 should be detached for use as the t	ian/Me	IF FEMALE: 23b. Was decedent past 12 months		1 Live b	outcome of preg pirth		etal death	3	Ectopic p	regnanc	y	1	23d. Date of d Month	Da	ay Ye	ar
OX 6	Sic		No 9 Unkno		ant at time of de	eath 5 O	ther (Specif	y)								
D. B the de	Phy	Part II. Other signi	ificant condition		- 1-10-61f	esulting in the	underlying c	ause gi	ven in Part	1.	23e. Did	d tobacc	co use contrib	ute to th	ne cause of dea	ath?
P.O. es that the igned by be detacl	d by										1 🗆 ነ	Yes 2	<b>✓</b> No 3	Proba	ably 4 Unk	known
rds, requir	Completed										24a. Wa	as an topsy			opsy findings av	
eco he law ite has	dmc						-					rformed	!? d∈	eath?		No
Vital Recysician: The his certificate director, page	Be	25. Was case refer	red to medical				26	.Place	of Death (C	Check onl	La			_		
Vita hysicia this co	0	examiner?	2 No	Hospital: 1 1	Inpatient 2 🗸	ER/Outpatien	t 3 DO	Α	Other 1	Nursing I	Home 5	Resi	idence 6	Other:		
Division of Vital Records, tal or Attending Physician: The law requirers after death.  In Director: After this certificate has been sided in by the funeral director, page 2 should be	ion: T	27. Manner of Deat  1 Natural	th 5 Pendin	28a. Date (Month Dec 12,	of Injury 1, Day Year) 2009	28b. Time of 0048 hrs			at Work? es 2 ✔ N	lsı	Bd. Describ ubject sl		injury occurre	d		
ivision or Attend after death Director: I in by the	ertification	2 Accident 3 Suicide	Investig	28e Place	e of Injury - At h	ome, farm, stre	et, factory, o	office bu	iilding, etc.	28				r or Rur	al Route Numbe	er, City
Divis pital or At ours after d eral Direct filled in by	Certi	4 V Homicide	determi		Townhous	e / Rowhou	ise			33	or Town 05 Wood	, State) Istock	Avenue, Ba	ltimore	, MD	
Division of Vital Records, P.O. Box 6876 within 14 hospital or Attending Physician: The law requires that the death certificate within 14 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the total page.	edical (	29a. Certifier 1 (Check only one) 2		sician: To the bes	of examination a											
To CON	Mec	29b. Signature and	title of certifier	and manner s	stated.	1	29c.	License	number			29	d. Date signe	d (Mon	th, Day, Year)	
	į	lals	M	11	4/	(		O.C.N	И.E.			D	ecember 1	12, 20	09	
Hu		30. Name and addr			. /			D. 111		D 0400	24					
47		Zabiullah Al	·	ssistant Medic	egistrar's Signati	0 11	nn Street	Baltin	more, M	D 2120	) [	-	· · · · · · · · · · · · · · · · · · ·			
St Regist	ate	31. Date filed (Mon	uusuay, xeari,	2009 22	egistrar's Signati	J. 496	0.0									

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09-09678 Dante Johnson-T	urne	Please Type or Print in Black Indelible Ink. Ensure All Copies  State of Maryland / Department of Health and Mental Hy	s Are Legi giene	ble.	10010						
	F	For State Certificate of Death	Reg.	No. 200	3 40212 3. Time of Death						
Physicia Medical Examin	er	Danté Antoine Johnson - Turner	Date of Death     Month	Day Year 2, 2009 4c. County of Death	2000 hrs						
		4a. Facility Name (if not institution, give street and number)  Sinai Hospital  Baltimore		N	A						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  29 9 1 9 1 1 M 2 F 29 Yrs.  Months Days Hours Min.	8. Date of Birth(	(MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State or n untry) MD						
Ą	- 1	Usual Residence of Decedent  10a State 10b, County 10c, City, Town or Location			10d. Inside City Limits						
yland -f show any once.	- 1	MD Battimore Randall stown  10e. Street and Number 10f. Zip Code	100	, Citizen of What Cour	1 Yes 2 No						
the Mar a or 28a	Director	8624 Pilsen Road 21133		USA							
eath with 1 items 23s	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 17 Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,						
after d	J.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	work done	Specify: 3(0	ndustry						
2 hours "natur		Flementary/Secondary (0-12) College (1-4 or 5+)		United 5	<b>States</b>						
0036 vithin 7 ene. er than Medica	Completed	12 H grade N/A Stocker  17 Father's Name (First Middle Last)  18 Mother's Name	/First Middle Ma	Govern	rnent						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	Danny L. Johnson Lucill	e V.T	urner							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F  SL24 Pilsen Road	Randal	Istown M	) 21133						
ore, I	Î	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Owings							
altimore, mit. Pages I an partment of Hea pportant: If iter iury or other tr.		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility \ Q	21 101 T	Greener	real SUCS						
Baltíl permit. Departm Importa		Vaugh C. Gr 8728 Liberty Rog	id Rand	laustown r	ND 21133						
Physician // /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sud to cardiac of failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death						
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
ecuted and transit	<del>-</del>	d									
50, te be ex ysician	ledic	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ry						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Medica	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	ancy	Month	Day Year						
t of Vital Records, P.O. Bing Physician: The law requires that the de After this certificate has been signed by the lineral director, page 2 should be detached it	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute t	o the cause of death?						
IS, P quires then signe and be d	ted by		24a. Was a	an 24b. Were a	utopsy findings available						
COrc law re has be	Completed		autop: perfor 1 <b>V</b> Yes	med? death?							
n Re m: The rtificat tor, pag		25. Was case referred to medical 26.Place of Death (Check									
Vita Physicis r this ce al direc	To Be	1 Yes 2 No		Residence 6 Oth	er:						
on of nding P th. r: After re funer		27. Manner of Death  1	Subject sho								
Visic or Atter fier dea Director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S	State)	Rural Route Number, City						
Di Ospital hours a ineral J	Cert	4 Homicide (Specify) Local Street  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		Heights Avenue, Ba							
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	at the time, date	and place, and due to	the cause(s)						
t.2t.8	Me	29b. Signature and title of certifier 29c. License number	OME	29d. Date signed (M. December 15,							
T 6,		30. Name and address of person who completed cause of trath (Item 20a)									
51		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 2120	1							
Si Regis	tate trar	TO THE DAY OF THE PARTY OF THE									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Cert	ificate of	Death			Re	eg. No.		4021	
Physician edical Examine	/ er	1. Decedent's Name (First, Midd	HEE		1147				2. Date of Dea Month December	of Death 5 hrs			
		4a. Facility Name (if not institution 15527 North Platte D	-	mber)	4	b. City, Tow Bowie	n, or Locati	ion of Death	Prince George's				
Funeral Director		5. Social Security Number un ⊬	6. Sex	7. Age (In yrs. las	st birthday) Yrs		_	Jnder 24Hrs. ours Min.	8. Date of Bir	th(MM/DD/YYYY) 9.	reign	State or  Kon OH	
1215-0036  be filed within 72 hours after a mail Hygorian mail Hygorian free do not than "natural", ent, the Medical Examiner.	10 be completed by runeral Director	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)  17. Father's Name (First, Middle  19a. Informant's Name/Relation  19a. Method of Disposition	12. Was December 1 2. Was December 1 2. Was December 1 2. Was December 2 2. Was Dece	10c. City, T	Town or Location of Location o	on	No spectupation (Of gife. DO 1)  18.Mc Street and	ican, Puerto scify: Sive kind of v NOT use retire other's Name Number or F	vork done red)	Og. Citizen of What Coo it h	Dountry?  Country?  Country  Cou	side City Limits Yes 2 No  Ann, Black,  Ade)  As III6  State  M. D. J.	
ficate be execu	n/Medical Examiner	23a. Part I. Enter the disease, of failure. List only one caus: Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	b. Due to (or as a d.  AMENDED  a. Hanging Due to (or as a d.  AMENDED  23c. If yes, 1 Live	a consequence of) a consequence of) a consequence of) outcome of pregn	): ): ): 2	etal death	3 <u>E</u>	as cardiác o		23d. Date of del	Betw	oximate Interval een Onset and Death	
Records, P.C. The law requires that cate has been signed page 2 should be deta	Completed by	1 Yes 2 No 9 V U	nknown g Unkr	iown	<u> </u>		use given	in Part I.	1 Yes	psy prio ormed? dea	Probably 4		
Division of Vital    Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director.	Ď	examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Per 2 Accident Inv 3  Suicide 6 Co 4 Homicide	Hospital: 1  Inding estigation ald not be ermined Hospital: 1  Z8a. Date FOUND Dec 12  Z8e. Pla  (Specify	e of Injury h, Day,Year) , 2009 ce of Injury - At ho	nily	t 3 DO/	Othe Injury at Yes	Work? 2 V No	28d. Describe Subject ha 28f. Location or Town, 15527 North	(Street and Number of State) Platte Drive, Bowi	or Rural Rou e, MD		
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Ex 29b. Signature and title of certification of the second of the secon	aminer: On the basis and manner ier  July and manner on the basis and manner ier  on woo ompleted cal	of examination ar stated.	nd/or investiga	29c. L	icense nui	ath occurred	at the time, dat	use(s) and manner as e and place, and due 29d. Date signed December 13	(Month, Da		
Sta		Jack Titus MD. De	eputy Chief Med	ical Examiner Registrar's Signatu		nn Street,	Dailling	ле, IVID 2	1201				
Registr		DEC	172009	Denous	ORIGINA	Berlo	N				COME		

09-09474	
Kevin Brian King	v

Neviii Bilaii Kilig		State of Maryland 1- For State Registrar	Certificate		io Mental H	, ,	eg. No. 200	9 4021
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)  Kevin Brian King				2. Date of Deat Month December		3. Time of Death 1250 hrs
		4a. Facility Name (if not institution, give street and number Prince George's Hospital Center	')		r Location of Death		4c. County of Death	
Funeral			ge (In yrs. last birthday	Cheverly  y) If Under 1 Yea	ar If Under 24Hrs	8. Date of Bir	th(MM/DD/YYYY) 9. Birt	hplace (State or
Director			55	Yrs. Months Day	ys Hours Min	Oct. 1	, 1954 Foreig	n Inginia
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Li	ocation				10d. Inside City Limits
Varyland 28a-f show any 1 at once.	ŗ	Virginia Warren	Front R					1 X Yes 2 No
he Mary or 28a ified at	Director	10e. Street and Number 704 Parkview Drive		10f. Zip Code 2263	0	11	0g. Citizen of What Cour	itry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Deceden		. Was Decedent of His If Yes, specify Cubar	spanic Origin? ( S			can Indian, Black,
fter deat  ", or its er mus	/ Fun	3 Widowed 4 Divorced If Yes, Give Year	2 X No	Yes 2 X No		reduit, etc.)		Black
hours at natural Examin	ed by	15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Dece	edent's Usual Occupa	ation (Give kind of		16b. Kind of Business/I	
136 thin 72 le. than "quedical I	Completed	Elementary/Secondary (0-12) College (1-4 or 2	5+)	ılation Ma			   Media Pres	SS
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)			18.Mother's Name		Maiden Surname)	
2121 uld be 1 Mental marke c event	To Be	Robert F. King  19a. Informant's Name/Relationship (Type, Print )	19b. Ma	ailing Address (Stree	Margare		nms  Ther, City or Town, State	Zip Code)
MD nd 2 short and m 27 is aumatic		Keith King (Brother)	184	Clay Hill	Dr., Wi		r, VA 22602	
nore, MD Pages I and 2 sh ent of Health an nt: If item 27 i		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from S	tate crematory o	sposition (Name of ce or other place)		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21 Signatur of Funeral Service Licenses		le Cemeter			Luray, VA	
	4	23a. Part I. Enter the disease, or complications that caused	d the death. Denot on	1200 N. SI	henandoal	n Ave.,	Home Front Royal	
Physician /Medical	ļ	failure. List only one cause on each line.	intoxicat		, such as cardiac c	or respiratory arri	est, snock, or neart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a cons						
	iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause	sequence of):					
sit sd	Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a cons	sequence of):	<u></u>				
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed ath or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	Medical E	d.  XUNPENDED AMENDED 22.	a,PII,27,2	9a f namel	7 ~900 1	/15/10		
760, icate be physici the buri	/Med	IF FEMALE: 23c. If yes, outco	me of pregnancy				23d. Date of delivery	
Box 687 e death certific the attending p	Physician/	past 12 months?	t time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	Month D	Pay Year
). Bo) the death by the att	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to deal	th but not resulting in f	the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
b, P.O. ires that the signed by I be detach	ē.	Atherosclerotic cardiova				1 Yes	s 2 V No 3 Prob	ably 4 Unknown
cords, law requir has been s	Completed				<del></del>	24a. Was autop		topsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26 Place	e of Death (Check	1 Yes		s 2 No
Vita hysician this cer	To Be	examiner?	ent 2 🗸 ER/Outpat		Othor:		Residence 6 Other	:
n of \alpha of \alphaoo \alpha of \alpha of \alpha of \alpha of \alpha of \alpha of \a		27. Manner of Death  1 Natural 5 Pending  28a. Date of Inj (Month, Day)	Year)	1	ury at Work? Yes 2 <b>X</b> No	28d. Describe I	now injury occurred	
by r de	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of It	njury - At home, farm, :	2:01 p			Street and Number of Rubber of Rubbe	ral Route Number, City
	- 1	4 Homicide determined (Specify)  29a. Certifier (Check only)  Certifying Physician: To the best of m	roadway					
To the Hos within 24 h	Medical	(Check only one)  1 Certifying Physician: To the best of mone)  2 Medical Examiner: On the basis of examiner stated.	amination and/or inves					
	ž	29b. Signature and title of certifier		29c. Licens O.C.			29d. Date signed (Mor	
	-	30. Name and address of person who completed cause of c	death (Item 23a)	0.0.	IVI. L.		December 6, 200	
XI		Margarita Korell MD. Assistant Medical	Examiner 11	1 Penn Street, B	altimore, MD	21201		
Sta	ate	31. Date filed (Month, Day, Year) 32 Registra	ar's Signature	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 12/14/2009 9:05 AM James E. Kelly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner New Windsor Carrol1 3104 Hooper Delight Rd. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 F (5/28/194) PA **Director** 68 165-32-9941 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 New Windsor 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 3104 Hooper Delight Rd. 21776 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 1058— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 1958-62 Specify: White 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Union Local #1 Stone & Marble Mason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Veronica Robel Robert Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3104 Hooper Delight Rd., New Windsor, MD 21776 Mary Ann Kelly/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 12/15/09 Signature of Funeral Service Licens Burrier-Queen Funeral Home & Crematory, P.A. ochl Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner respiratory failure Q Sequentially list conditions, Examine any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury discase -d ks attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, potension 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed Seizures 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eciton CRNP. A

Registrar

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Yea **Physician** Kveseth Dorothy 200 Pame la /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner SUG Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/23/1951 Birthplace (State Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🔀 F 58 Maryland 217-58-1079 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State d other than "natural", or items 23a or 28a-f show event, it o Modical Examinar must be notified at 1 XYes 2 ☐ No **Funeral Director** Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21060 7355 Furnance Branch Road East 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1∐Yes 2k No Specify. Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Security Admin Classified marked other 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file.
Thealth and Mental Hv.
The ST is mark. 17. Father's Name (First, Middle, Last) Be Kinder Genevieve ၉ Fredrick Williamson Dorothy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1922 Montevideo Road, Jessup, MD 20794 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Dorothy Kinder/ Mother Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/16/2009 Hanover, Maryland Anatomy Gifts Registry 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste.P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence te Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Saknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funera Certification: 27. Manner of Death 28a. Date of Injury After (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral D Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec. 11142009 0066019

State Registrar

DHMH 17 Bev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** 100 9:15 arroli 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Catonsville 8. Date of Birth (Month, Day, Ian. 19, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ★ M 2 🗆 F 1925 West Virginia 216-22-4340 Director 84 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 ☐ Yes 2 No Directo Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 709 Maiden Choice Lane RGT 430 23a 21228 United States Funeral tal Hygiene. d other than "natural", or items ? event, I's Medical Events and 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No 1944If Yes, Give
Year or Dates: 1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: ò Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processing Supervisor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H tem 27 is marked oth other traumatic even Be ပ **Ivah** Trago W. Lloyd Dav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. <u>Phyllis B. Lloyd/ Wife</u> 709 Maiden Choice Lane RGT 430, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 15, 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. pulmonare disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ficate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ fonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed? 2 □ No 1 ☐ Yes 2 400 funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State
Registrar

maiden

strar's Signature

hoice Lane, Cutonsville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

Bowlin

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pamela Marie Lester AM 9:47 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/A Baltimose Hospita of baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 F J*an.*^{th,} **29**, Year 1958 51 Hours 220-76-4806 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 by Funeral **USA** 2612 Taylor Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Yuhanek Melvin Kaye 19a. Informant's Name/Relationship (Type, Print)

Jack C. Lester, Jr. / husband Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Taylor Ave. Baltimore, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 12-13-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate Examiner cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗷 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No ER/Outpatient 3 DOA √Inpatient 2 □ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) KES 2009 11 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MABS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

Directo

Funeral

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating rust be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meonee.

Baltimore, Maryland 21215-0036

/Medical

sician and burial-transit To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

Be

Certification:

Medical

25. Was case referred to medical

31. Date filed (Month, Dav. Year)

Hospital:

5 Pending investigation

6 Could not be

1 🔲 Inpatient

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

2 ER/Outpatient

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 **☐** No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

29b. Signature

Division of Vital Records, P.O. Box 68760

				/					
	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	- Andden Curdiac death	or respiratory arrest,		Approximate Interval Between Onset and Death				
edical Examiner	1.45 A 40-								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of de Month	livery Day Year				
ted by Ph	Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.		_	o the cause of death? robably 4 \( \Boxed{1}\) Unknow				
E E									

3 DOA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAFAGL PENEZ-MENA 404 SATTERN BLVD - BALTIMORE, MD 21221

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D10613

1 ☐ Yes 2 ☐ No

autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) DAUGHTERS HOVE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 □Yes 2 □No

26. Place of Death (Check only one)

2 🗌 No

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1per Phy &20b&c Per FH G899 1/04/2010 JH

State of Maryland / Department of Health and Mental Hygiene

				cate of		Reg	. №. 2 <u> </u>	40222
	Physici		1. Decedent's Name (First, Middle, Last)  Duane Murphy, Sr.	•		2. Date of Death	Day 12 Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b.	City, Town, o	r Location of Deat		4c. County of Dea	th
1			3907 Fairview Ave	Balt				
	Funeral Director			Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y)	9. Bir 54	thplace (State or Foreign ountry) MD
	yland Iow at		10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
	a-f sh	ctor	MD NA Baltimo	ore				1 <b>X</b> Yes 2 □ No
	or 28 oe noi	Dire	10e. Street and Number . 10	of. Zip Code		10g	. Citizen of What Co	ountry?
	eath w is 23a nust l	eral	3907 Fairview Ave		1216	- No. of the second	U.S.1	
350	be filed within 72 hours after death with the Maryland nta! Hygiene. ed other than "natural", or items 23a or 28a-f show event, the "redical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Xes 2 □ No If Yes, Give Year or Dates;  1 □ Year or Dates;	es 2 XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)	14. Race - Am- Black, Whit Specify:	
12-0036	"natura	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind to the completed)	Usual Occup	oation during most of wor d)	l6 king	b. Kind of Business	/Industry
7	filed within Hygiene. other than "	dwo	Elementary/Secondary (0-12) College (1-4or 5+) Home 1				elf Empl	loved
	al Hyg other	BeC	17. Father's Name (First, Middle, Last)		*	ne (First, Middle, Mai		
ylar	hould be I Id Mental marked o matic eve	다	Ellis Murphy		Delore	s Marsha	11	
a	2 sho		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Add	·		ıral Route Number, C		
c,	1 and Healtl em 27		20a Method of Disposition 20b Place of Disposition	(Name of	1	Date 200	. Location - City or	Town State
Dalumor	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	al ^{the} Pal		2/18/09 Wo	odlawn, M Owings	p. Hills, Md
מ	Depar Impo any ir		1 thame the shampeur 4300	O Waba	ash Ave	ome West Baltim		21215
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line.	e mode of dyir	ng, such as cardiad	or respiratory arrest	1	Approximate Interval Between Onset and Death
pro jee	Physician /Medical		Immediate viuse (Final disease or condition resulting in death)	mcc	27			Onset and Death
	Examiner		Due to (or as a conseguence of):					
	p ±	ner	Sequentially list conditions, if any, leading to immediate neus. Ent. I have the constant of t					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events consulting in death) Last					
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	attendin for use	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Othe	opic pregnanc er <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
Ŀ	that the de ned by the detached		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause give	an in Pàrt I	23e Did tobac	co use contribute t	o the cause of death?
olds,	w requires to seen signer should be a	ted by						robably Unknown
ו חפר	: The law cate has t	Completed				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
<u> </u>	nysician: Thanis certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Oth		th (Check only one)		
5	Jing Phys I. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injur	yat	ome 5 Residence 28d. Describe how		ecify)
5	Attending ir death. ector: After by the fune	atio	Natural 5 Pending (Month, Day, Year) Injury	Work	₹? Yes 2 □No			
	al or Atte	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office		28f. Location (Stree City or Town, S		ural Route Number,
`	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Af completely filled in by the fur	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occumulation and/or investige and manner stated.	urred at the tir gation, in my o	me, date and place pinion, death occu	e, and due to the causered at the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)
/	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	29c. Licens	e number	29d.	Date signed (Mont	th, Day, Year)
			· coal from	D15	870	3 becc	ube!	5, 2009
/	61		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25-1	n. B	Die	se -	1269
	Stat Registra		31. Date filed (Month, Day, Year)  32. Degistrar's Signature					

State of Maryland / Department of Health and Mental Hygiene 40223 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** Bernard A. McClelland December 8. 2009 10:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 215 Delight Road Reisterstown <u>Baltimore</u> Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1/14/30 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ F 217-24-4428 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, tree Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 215 Delight Road Funeral 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) US Government 12 Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Flynn or other traumatic ဂ Arthur Kelly McClelland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau Kathleen R. McClelland Daug. 215 Delight Road Reisterstown, Maryland 21136 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/19/09 Baltimore, Mary 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 21. Signature of Funeral Service Lice 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels consequence off the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death Day 5 Other (specify) □Yes 2□No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩0 24a. Was an has autopsy performed? 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only orré) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Street (NOTHINSTER , MD 2115 Havio 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan  1 - State Amend Item 23a,29d per dr	d / Depa • ,898 • <i>Cel</i>	artment of l 12/17/09 hillicate of	lealth and Death	d Mental Hyg	giene eg. No. 200	9 4022
	Physicia		1. Decedent's Name (First, Middle, Last)  MARGARET  PO	ORE			2. Date of Deat Month DECEMBE	Day Year	3. Time of Death 4:30 a ^M
in any	/Medic Examin		4a. Facility Name (If not institution, give street and number) 614 KITTENDALE CIRCLE	0112	4b. City, Town, c	r Location of De	ath	4c. County of De	ath
	Funeral Director		5. Social Security Number 217-34-4896 6. Sex 1 M 2 XF 7. Age (In yrs.)	7 2 _{Yrs} .	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. B 937 MA	rthplace (State or Foreign Country) RYLAND
	Maryland a-f show	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City   MD   BALTIMORE   10b. County   10c. City	y, Town or Lo		DLE RIV	VER		10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a st be not	al Director	10e. Street and Number 614 KITTENDALE CIRCLE		10f. Zip Code	21220	1	0g. Citizen of What C	The state of the s
980	be filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, I'm Medical Evarriner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 □ ☒ O I ☐ Yes Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes X□ No	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: W	te, etc.
21215-0	_ 70	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire PUTER O	during most of w d)	orking	16b. Kind of Busines AMERICA STAT	·
/land	should be filed within and Mental Hygiene. s marked other than umatic event, the Mark	To Be (	17. Father's Name (First, Middle, Last) EDWARD	BOI	ND	18. Mother's N ADA	ame (First, Middle, M ROS	,	HITTEN)
, Mar	d 2 :	,	19a. Informant's Name/Relationship (Type. Print) ROY L. POORE/HUSBAND		ng Address <i>(Street</i> KITTEND			r, City or Town, State, DDLE RIV	Zip Code)21220 ER, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	emetery, cren ETRO (		RY 12-	-5-09 VACH/ROS		ILLE, MD NERAL HOME
and part	Physician /Medical		resulting in death)	n. Do not ent	er the mode of dyi	ng, such as card		est,	Approximate Interval Between Onset and Death
8760,	cate be executed by physician and the burial-transit	dical Examiner	Sequentially list conditions, tay leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of t	ience of):					
O. Box 6	ne death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of d Month	elivery Day Year
rds, P.	quires that the ser signed by and be detac	र्व	Part II. Other significant conditions contributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot		to the cause of death?  Probably 4 Unknown
of Vital Records,	n: The law requir ficate has been s r, page 2 should	Completed					24a. Was a autops perforr 1 □ Yes 2	sy prior to med? death?	autopsy findings available completion of cause of
of Vit	ding Physician: The I h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2				eath (Check only on Home 5 Reside	ence 6 ☐ Other (Sp	pecify)
Division o	Attending Prdeath. ector: After by the funera	ation:	27. Manner of Death  1 Natural 5 □ Pending (Month, Day, Year)  2 Accident investigation	28b. Time of Injury	Wor	ryat k?  Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stro	eet, factory, office		28f. Location (St City or Town	treet and Number or in, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	29a. Certifiler (Check only one)  12 CertifyIng Physician: To the best of my kno Medical Examiner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death of	ace, and due to the courred at the time, d	cause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier		29c. Licens	se number		9d. Date signed (Mod December 6	
			30. Name and address of person who completed cause of death (Item 9512 Horford Ko	23a) (Type,	Print) Cook	e4 1	BALTO	MD2	1234
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signar 2009	ture	led led			-	

# Proctor, Anthony

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			For State Registrar			viai yiaiiu		rtificate					Reg.	0.0	09	40225
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	Exami		4a. Facility Name ( Sinai Hos		e street and numb			4b. City, To						4c. County	y of Death	
	Funeral Director		5. Social Security N	2571	Sex 7.	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month	Birth Day, Yea	ar) 48	9. Birthp Cour	place (State or Foreign htry)
	iryland show		Usual Residence o 10a. State	10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	r 28a-f	Director	MD 10e. Street and Nu	NA mber		Ва	altin	10f. Zip C	Code				10a.	Citizen of	What Cour	1 XYes 2 □ No
	ath with		2300 Ti	oga Par	kway Ap					2121					S.A.	
980	be filed within 72 hours after death with the Maryland that Hygiene.  Identify than "natural", or items 23a or 28a-f show event, the Medical Evaluation of the Medical Evaluat	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	ied 🌠 Married	12. Was Decede Armed Force 1 Tyres 2 I If Yes, Give Year or Date	es? □ No		Was Decede If Yes, specif 1 □ Yes 2		ispanic Or In, Mexica Specify.		ecify Yes or Rican, etc.)	No-		ce - Americ ck, White, c	
21215-0036	"natur	leted	(Spec	15. Decedent's E	ducation ade com <i>pleted)</i>		(Give	dent's Usual kind of work	done o	lurina mos	st of worki	ing	16b.	Kind of B	usiness/Ind	iustry
	should be filed withir or Mental Hygiene. marked other than matic event, the Mental control or matic event, the Mental control or matic event, the Mental or matic events are matic events and events are matic events are matic events and events are matic events are matic events and events are matic events are matic events and events are matic events are matic events are matic events and events are matic events are matic events are matic events are matic events and events are matic events are matic events are matic events are matic events and events are matic events are ma	Completed by	12th gr	ade	College (1-4d <b>na</b>	or 5+)		struc			ork	er	С	onst	ruct	ion Co.
Maryland	be od o	Be	17. Father's Name		)				ĺ			e (First, Mia		<i>en Surn</i> an	ne)	
aryl	d 2 should be fith and Mental H 7 is marked of traumatic ever	မ	Roger P		Type. Print)		19b. Mailir	ng Address (	Street a		-	rocto al Route Nu		y or Town,	, State, Zip	^{Code)} 21215
	1 and Health		Brenda 20a. Method of Dis	position		20b. Plac		Tioo sition (Name natory or oth				Apt_			imor City or To	e, Md
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		4 ☐ Donation	5 Other (Specif		te cen	On-S	ite		1	-	1/09	Ba	ltim	ore,	Md
Bal	permi Depar Impor any ir		21. Signature of L	Ineral Service Licer	Mark		Ma	Name and	7/H	Wes	t	balt	imo	re,	Md 2	1215
	Physician /Medical		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	rt fallure. List only (Final	plications that caus one cause on each	ine.	Do not ent	er the mode	of dying	g, such as	cardiac o	or respirator	ry arrest,			Approximate Interval Between Onset and Death
68760,	be executed ician and purial-transit	lical Examiner	Sequentially list cuif any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) I		b. Due to ora	as a consequent of the consequ	1600):	Cope	cho	in	Perc.	tevs	ol	i Jeas		Jow minute. Years
.O. Box 6	The law requires that the death certificate I ate has been signed by the attending physicage 2 should be detached for use as the E	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?		n 2 🗆 Fetal de t at time of dea	eath 3	Ectopic pred					_		te of delive	ery Day Year
ords, P.	w requires that s been signed b should be deta	ted by Pł	Part II. Other signif	on ol Ab	ontributing to death	but not resulting	ng in the ur	derlying cau	se give	n in Part I.			id tobacc		3 Prob	ne cause of death?
Division of Vital Records,	i <b>ician:</b> The law r certificate has bu ector, page 2 sh											24a. W au pe 1 □ Ye	utopsy erformed?		prior to cor death?	psy findings available npletion of cause of 2  No
f Vit	nysicia nis certi directo	To Be	25. Was case referrexaminer? 1 ✓ Yes 2 □		Hospital: 1 1 npa	ıtient 2 ☐ EF	R/Outpatien	t 3 DOA	Othe	r.		<i>(Check on</i> me 5 □ R		6 □ Oth	ner (Snecifi	v)
o uc	ding Phys J. After this funeral dii	L:uoi	27. Manner of Deatl 1 Natural	5 Pending	28a. Date of Ir (Month, L		Bb. Time of Injury	280	. Injury Work	at ?	2	28d. Descrit				<u>/</u>
Division	To the Hospital or Attending Physician: The la within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	28e. Place of I	njury - At home etc. <i>(Specify)</i>	e, farm, stre	M eet, factory, o		′es 2 □ l		28f. Location City or	n (Street Town, Sta	and Numb	per or Rura	l Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifler (Check only one)	1 Certifying Ph 2  Medical Exam	ysician: To the bearinger: On the basis and manner:	ot examination	edge, death n and/or inv	occurred at restigation, in	the tim	e, date ar inion, dea	nd place, ath occurr	and due to ed at the tin	the cause	(s) and mand place,	anner as si and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and	title of certifier	101.0		<u></u>	29c. L	icense	number	SO	0	29d. [	ate signe	d (Month, i	Day, Year)
1	H.,	-	30. Name and addre	ess of person who	completed cause of	death (Item 23	3a) (Type, F	Print)	I.	0 1	<u>00</u>	M., 1	1	2114	189	
	Sta Registra		31. Date filed (Mont	h, Day, Year) IEC 1720	09 32. Regis	M // strar's Signatur	140	asked a	J.	Belu	ucle	My.	beli	ino,	М,	MN
DUA	IH 17 Pey 1/20		-			0	98	<del></del>	_							

State of Maryland / Department of Health and Mental Hygiene 40226 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12/15/2009 Dennis Pearson 4:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Brooklyn Park 303 Grove Park Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/02/1962 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 220-82-7892 Yrs. Director 47 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Anne Arundel Brooklyn Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ? 303 Grove Park Road 21225 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 12 Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evance. David Pearson Darlene Grabar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Grove Park Road, Brooklyn Park, MD 21225 Regina Pearson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 12/16/2009 |Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee 1|7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PTA-5 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Park.

CHROPIC OSSTON TOTAL FOLMONORY DISFAS 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 | Yes 2 | No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No filled in by the fi 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUGAMEM PC. 227 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09734 State of Maryland / Department of Health and Mental Hygiene Robert Gerald Paulus 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1534 hrs Medical Examiner Robert Gerard Paulus December 14, 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/ARaltimore 612 Evesham Avenue 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min Director Country) Maryland 58 19. 1951 1 × M 2 F Yrs 213-60-1248 Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 1 Yes 2 No 28a-f show s 23a or 28a-f shov e notified at once Maryland N/A Baltimore irector death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ā 612 Evesham Avenue 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes 0 White Specify: 1 Yes 2 X No specify: 3 Widowed 4 X Divorced If Yes Give Year or other traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Important: If item 27 is market. Elementary/Secondary (0-12) College (1-4 or 5+) Compl 4 years Painter Home Improvement 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Alexander Furlong Joseph Paulus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 814 Cathedral Street #3F Patrick Paulus (son) Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Green Mount Crematory 12-16-09 Baltimore, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, In
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service License Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Asphyxia Immediate Cause (Final disease ⊆xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or tributy that initiated Due to (or as a consequence of): events resulting in death) Last and transit o the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical  $\mathbf{x}$  AMENDED 1 per me g899 1-5-10 23a,27,28a-f,permE, g 10 yt g899 1/6/10 TT X UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed' ✓ Yes ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Natural 1 Yes 2X No auto-erotic asphyxia 5 Pending Director: death. Fd 12/14/09 unk 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be BAITIMOTE, MD (Specify) home within 24 hours a To the Funeral I determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHIVIH 17 Rev 1/2001 OCME 2006

State

Registra

29b.

2009

Assistant Medical Examiner

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month. Day Year)

December 15, 2009

Laron Locke MD

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40228 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 1/3, 2009 Young Sook Park 1634 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) June 28, 1948 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Country) Korea Director 149-58-0314 S. 61 June Usual Residence of Decedent f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2X No MD Montgomery Potomac 10e. Street and Numbe 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than 4- any injury or other traumati-10916 Martingale Court 20854 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married <u>۾</u> 1 ☐ Yes 2X No Specify: If Yes Give Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kuk Ja Shin Dong Joon Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip John McGann/husband 10916 Martingale Court Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 12/15/09 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊕nysician/ Metastatic Gastric Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Malignant Pleural Effusion Sequentially list conditions day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the bunal-transit Acute Respiratory Failure that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Cerebrovascular Accident P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month 5 Other (specify) Day Year Pregnant at time of death the 1 ☐ Yes 2 ☐ Unknown g 🔲 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 performed? Yes 2 No or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 XNo ည 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Later death.

**I Director: After the 'in by the fundamental'. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Ganti, M.D. 19529 Doctors Drive Germantown, MD 20874 32. Registrar's Sanature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year, December 14, 2009

29c. License number

D41162

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #49a Per Mayland Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Keese resa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Ba Itimore OWSON 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) **Funeral** South Carolina (Month, Day, Year) 109-20-5077 1 M 2 X F Days Hours 83 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 XYes 2 □ No timove 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code # Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced "natural", other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dress Elementary/Seconday (0-12) Factory if Health and Mental Hygiene. item 27 is marked other than ' College (1-4 or 5+) grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robinson Haywaro louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spaulding 2702 Ave #15 HIMOTE, MD Daughter .rbara 12/22/2009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State or other place) Site 4 ☐ Donation 5 ☐ Other (Specify) Crem 22. Name and Address of Facility March Funeral 21. Sign turn of Funeral Service Licensee Home-West 4300 Wabash Baltimore, MD21215 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to v as a consequence of) **Examiner** Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) N) SOLU မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 0

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of persor

ho completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician  $A^{M}$ 10, 2009 9:35 December Shekarchi Christison Isabel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Montgomery Bethesda 9802 DePaul Drive 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 1922 Minnesota 87 Director 476-20-1891 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Bethesda Directo 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 20817 9802 DePaul Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Science Microbiologist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred Burns John Smith Christison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9802 DePaul Dr., Bethesda, MD 20817 Edraham Shekarchi (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State High View, WV Timber Ridge Cemetery 12/15/09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Giffin Funeral Home, Inc. 21. Signiture o Funeral Service Li P.O. Box 100 Capon Bridge, WV 26711 Mme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer 3 Years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the January Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No sate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 X No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 24 hours a e Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number ertifier nd little of 29b. Signature December 12, 2009 MDD33554 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 5410 Connecticut Ave. NW #110 Washington, DC 20015 John Yerg, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature 32 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $A^{\mathsf{M}}$ 2009 1:25 14, December Genevieve M Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mitchell ville Prince George's Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, ) Jan. 22, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2X F Yrs. 1928 Washington, DC 81 Director 105-24-4195 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Calvert Huntingtown the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2 should be filed within 72 hours after death with Is and Mental Hygiene.

Is marked other than "natural", or items 23a or 2 20639 322 Kims Way U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☑ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Fashion Designer Fashion 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise DuPlessis ို Charles Masse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Kims Way, Huntingtown, MD 20639 Sean F. McAllister (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any Injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Columba Cemetery 12/18/09 Middletown, RI 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Juneral Service I cen 22. Name and Address of Facility Fagan-Quinn Funeral Home 825 Boston Neck Rd., N. Kingstown, RI 02852 Mun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HOUHON A to (or s 100 disease or condition resulting in death) /Medical Due a consequence of) Examiner +noke Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 2 Accident 5 Pending investigation Injury s after oe... ral Director: Atte 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8116 GOOD LUCK A 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Dark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Linda Harriett Smith Medical 2009 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 3900 Gwynn Oak Ave Apt T-4Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Hours 1 □ M 2√□ F 218-42-8585 Director 64 29 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No MD NΑ Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21207 3900 Gwynn Oak Ave Apt T-4 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Corp 10th grade na Coke Oven Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lynch Evelyn Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Nassau Street, Pikesville, Md 21208 Stephanie Rubin-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/16/2009 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Ma 21215 Baltimore, md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Caroli vasantas Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence oi). and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 18 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of COPD 24a. Was an cate has page 2 s performed No death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this After this funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending injury work? within 24 hours after death.

To the Funeral Director Aft
completed filled in by the fu □ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0061347 Mann. Mis.

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

ORIGINAL

Came

315 N.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 5per FH, G898, 12/23/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 40233 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 908 **Physician** TRATTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arunde1 Annapolis 9. Birthplace (State or Foreign Country) Ashland, KY 8. Date of Birth (Month, Day, Year) Aug. 8,1920 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Davs Hours 89 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10q. Citizen of What Country? 10f Zin Code 10e. Street and Number 305 Rainwater Way 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2♠No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2.\ If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event, the Medical Exeminany injury or other traumatic event, the Medical Exeminany Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White <u>۾</u> 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Stevens Ora Owsley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Kelly R. Stratton /Son 1589 Long Point Road Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 18, 2009 Glen Burnie, MD 4 Donation 5 Dother (Specify) 21. Signat Funeral Service 22. Name and Address of FacilitySingleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnle, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final P51 **Physician** disease or condition resulting in death) /Medical UNINARY TRACT INFRAIN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusity (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type PDEFENSE HIGHWAY ANNAPOLIS MIDZIFON

Registrar

State

Date filed (Month, Day,

Year)

Barken

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29c&d per MD G898 12/17/09 TT #30 per DVR State of Maryland Department of Health and Mental Hygiene State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6, Physician/ Catherine Stevens December Ann 2009 2:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1931 Barry Road Dunda1k Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth Month, Day, Ye Days Hours Min 1 🗆 M 2 🔯 F Months Mary land Director Yrs. 216-16-0951 85 ĭ924 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Me Ical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 🗆 Yes 2 🏝 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21222 United States 1931 Barry Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 'natural", Specify: Completed 3 Widowed 4X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 721 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Administrative 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Koop George Bitter permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 21237 6612 Kenwood Ave. Baltimore, Maryland Rhonda Noll (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕏 Other (Specify) Entombrien of Faith Cem. 12/10/2009 Baltimore, Maryland <u>Gardens</u> 21. Si ature V uneral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that yoused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause A such line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Medical Examiner to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of: -transit Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown To Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 1 Yes 2 No Yes apleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 4 Nursing Home 27. Marmer of D 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertitiving Nurse Practioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D0030149 Dec. 7, 2009

State

Registrar

#302

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

DEC

Hector Silva, MD

TOWSON

WD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 200 secrae E. Scott 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death altmort Vear | If Under 24 Hrs. Medical Center MOVEY N/A Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) Days Hours Min. Months 1 XM 2 ☐ F 8-23-1927 MARYLAND 82 217**-**22-0676 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2786 W. NORTH AVE <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 3 ☐ Widowed 4 🌣 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY GENERAL MOTORS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELISAH B. SCOTT ARMENIA SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SAUNDRA SCOTT (DAUGHTER) 14 TORLINA CT. GWYNN OAK. MARYLAND 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5/ Other DRUID RIDGE CEMETERY: 12-23-2009 BALTIMORE, MARYLAND D. HIBNIR^{2. Name and Address of Facility} PHILLIPS FUNERAL HOME, P.A. 21. Signature of F 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, if heart failure. List only one cause on each line.

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD.

**Funeral Director** 

à

Be Completed

2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene "Instural", or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. once.

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-trai attending physician for use as the buria ned by the signed by to be a signed the filled in by

Division of Vital Records, P.O. Box 68760,

Immedi e d'ause (Final disease tr'ondition resulting in death)	a. Advanced lung concex  Due to (or as a consequence of):		10/2009
Sequentially list conditions, if any, caoing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Curriu (cras a consequence of):  c. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ ☐ ☐
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
1 Yes 2 1 Vo	Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inju	
3 Suicide 6 Could not b		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place,		

State Registrar

To the Hospital of within 24 hours at To the Funeral D

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

enter, 301 St. Paul Place, Balt more, MD 21262

and manner stated

Mercy

Medi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Wade Patricia Α. 2009 20a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Manor Care Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days 1 . M 2 . F Hours Country) Director 217-64-6139 55 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 709 Yale Ave 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ρ 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harper Hospital lementary/Seconday (0-12) College (1-4 or 5+) 12th grade lýr Unit Secretary Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lee Worsham Anna Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wade-Husband Yale Ave Baltimore, Μđ 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 12/19/09 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Simate a of Funeral Service Licensee 221215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 27 116 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

QV State Registrar 3 🖂

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

Registrar's Signat

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ician	1 - State Registrar	Certificate of Death	Reg. No. 2009 4023
dical	1. Decedent's Name (First, Middle, Last)  Dorotny Williams		2. Date of Death Month Day Year 1254
niner al	4 🗆 11 0 15/6	il Baitmore, Mp	8. Date of Birth (Month, Day, Year) O5 12 11 9. Birthplace (State or Fore Country) NY
or	217-12-6215	10c. City, Town or Location	05 12 11 NY
To Be Completed by Funeral Director	MD NA	Baltimore	1 XXYes 2 □ 1
al Dire	10e. Street and Number 3800 West Belvedere A	10f. Zip Code 21215	10g. Citizen of What Country?  U.S.A.
by Funeral	11. Marital Status  1 Never Married 2 Married  1 Was Decede Armed Force 1 Yes Xi If Yes, Give 1 Was Decede 1 Yes Yi If Yes, Give Year or Date	ent Ever in U.S. es?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4c)	16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	ng
	9th grade na 17. Father's Name (First, Middle, Last) Unkn	Stock Clerk_	Hutzlers (First, Middle, Maiden Surname)
To Be		Mary Fos	
	19a. Informant's Name/Relationship (Type. Print)  Virginia Evans-Daught		al Route Number, City or Town, State, Zip Code) 2120 eet Apt 15m, Baltimore,
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
	21. Signature of Funeral Service Licenses	22. Name and Address of Facility March F/H West 4300 Wabash Ave,	
l	shock, or heart a ure. List only one cause on each	ase! the death. Do not enter the mode of dying, such as cardiac of hiline.  The struction  as a consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
cal Examiner	Cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last  Disease or Di	as a consequence of):	
15	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor	th 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ysician/Me	in the past 12 months?  1 ☐ Yes 2 🗷 No 9 ☐ Unknown	nt at time of death 5 □ Other (specify) vn	
d by Physician/Medical		vn	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
		vn	
Be Completed by	25. Was case referred to medical examiner?  1 Pes 2 No  27. Manner of Death 1 Matural 5 Pending  Hospital: 1 Inp.  28a. Date of (Month,	th but not resulting in the underlying cause given in Part I.  26. Place of Death  Deatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Hor  Injury 28b. Time of Jav. Year) Riging Work?	1 Yes 2 No 3 Probably 4 No American Probably
Be Completed by	25. Was case referred to medical examiner?  1	26. Place of Death  27. Deatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Hor Injury Day, Year)  M 1 Yes 2 No	1   Yes 2   No 3   Probably 4   Which of the state of the
Certification: To Be Completed by	25. Was case referred to medical examiner?  1	26. Place of Death  27. Place of Death  28. Place of Death  28. Injury at Mork?  M 1 Yes 2 No  Injury - At home, farm, street, factory, office  est of my knowledge, death occurred at the time, date and place, is of examination and/or investigation, in my opinion, death occurre	1   Yes 2   No 3   Probably 4   Unkno  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2   Yes 2   Yes 3   Yes 3   Yes 4   Ye
Be Completed by	25. Was case referred to medical examiner?  1 Pes 2 No  27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 ertifying Physician: To the best and manner.	26. Place of Death  27. Place of Death  28. Place of Death  28. Injury at Work?  28. Injury at Work?  3	1   Yes 2   No 3   Probably 4   Unkno  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2   Yes 2   Yes 3   Yes 3   Yes 4   Ye

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		State Registrar		Cer	tificate of Death			Reg. No. 2	09	40238
Physicia Medic		Decedent's Name (First, Middle, Last)     Charles Leroy Widern					2. Date of Dea Month 12/	th L6/2009	Year	3. Time of Death 2:30 P M
Examin	er	4a. Facility Name (if not institution, give street and nul			4b. City, Town, or Location			4c. County	of Death	0.00
Funeral		8424 Merrymount Drive 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year If Und	der 24 Hrs.	3. Date of Birth		g. Birthp	lace (State or Foreign
Director		212-22-7397 1 XM 2 F Usual Residence of Decedent	81	Yrs.	Months Days Hour	s Min.	(Month, Day 6/15/	1 9 28	Count	MD
yland f sho	ctor	10a. State 10b. County	10c. City,	Town or Lo	cation				10	0d. Inside City Limits
r 28a- notifi	Dire	MD Baltimore  10e. Street and Number		Winds	or Mill 10f. Zip Code					1 ☐ Yes 2 🛣 No
with th	Funeral Director	8424 Merrymount Drive	<b>.</b>		21244			10g. Citizen of W USA	/nat Coun	try?
items items er mu	Ē		edent Ever in U.S.		Nas Decedent of Hispanic f Yes, specify Cuban, Mexic			14. Race	e - America	
after o	ρ	1 Never Married 2 Married 1 Yes	2 No ve lates. 1950-5	_ 1 _	Fes, specify Cubari, Mexic		can, etc.)	Black Specify:	k, White, e	
hours natura ical E	letec	15. Decedent's Education			dent's Usual Occupation			16b. Kind of Bu	WILL	
in 72 e. nan "r Med	Completed	(Specify only highest grade completed Elementary/Seconday (0-12) College (	1-4 or 5+)	(Give	kind of work done during m O NOT use retired)	nost of working	7	TOD. KING OF BO	311633 1110	ustry
d with lygien ther ti nt, th	Be C	12		Bus	iness Owner					Campers
be file ental H ked o c eve	70 E	17. Father's Name (First, Middle, Last)  Charles L. Widerman						Maiden Sumame ne Roger	,	
hould and Ma s mar umati		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street and Nun	-				iode)
nd 2 sl ealth a m 27 i		Lucille Widerman/Wife	2		Merrymount					,
ge 1 ar t of Ha <b>If iter</b> or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from			sition (Name of natory or other place)	Da		20c. Location -	City or To	wn, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	Lake		Mem. Park	12/19		Sykesv		
permi Depar Impor any ir		21. Signature of Funeral Service Licensee			Burrierdote 1212 W. Old					
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. ach line.	Do not ente	er the mode of dying, such	as cardiac or	respiratory arre	est,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Cong	est	me Hea	ut t	alle	ve		Onset and Death
Examiner		Due to	(or as a conseque	fice of):	un o Da	The				1 year
- ±	Examiner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying	(or as a conseque	nce of):		1				
and trans	xan	Cause (Disease or iinjury that initiated events c.	(or as a conseque	ince off:					_	
be executed sician and burial-transit	cal	d	(							
ificate ng phy as the	Medi	IF FEMALE:		-						
th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?		death 3	Ectopic pregnancy				e of delive	
re dea	Physician/Medi	1 ☐ Yes 2 ☐ No 4 ☐ Prei 9 ☐ Unknown 9 ☐ Unk	gnant at time of de nown	eath 5L	Other (specify)			Mor	1111	Day Year
that the ned by e deta	by Pi	Part II. Other significant conditions contributing to		-		art I.	23e. Did to	bacco use contri	ibute to th	e cause of death?
quires en sig ould b	ted	Alzhein	evs.	ac	sease		1 🗆 ነ	es 2 No	3 🗌 Prob	pably 4 🗆 Unknown
law re has be e 2 sh	Completed	ANUL	1 br	ill a	Jun		24a. Was a autop	sy p	prior to con	osy findings available inpletion of cause of
n: The ficate n, pag		25. Was case referred to medical					perfor 1 Yes		leath?	2 No
ysicial s certi directo	To Be	examiner? Hospital:	Inpatient 2 🗆 E	R/Outnatier	_ Other:	Death (Check of	1	ence 6 🗌 Othe	r (Specific	
ng Ph tter thi meral	rte: 1	27. Manner of Death 28a. Date		28b. Time of injury				ow injury occurre		
ttendii death. tor: A the fu	Certificate:	2 Accident Investigation	-0: 40		M 1 ☐ Yes 2					
al or A s after Il Directed in by			e of Injury - At hom ling, etc. (Specify)	ie, iarm, str	eet, factory, office	28	City or Town	treet and Numbe n, State)	r or Rurai i	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the ba	sis of examination :	and/or inves	tigation, in my opinion, death	h occurred at th	ne time, date ar	nd place, and due	to the cau	ise(s) and manner state
o the vithin 2 o the controlle	ž	only one) 3 L Certifying Nurse Practioner  29b. Signature and title of certifier	To the best of my I	knowledge,	death occurred at the time, of 29c. License number	date and place,	and due to the	cause(s) and ma	nner as sta	ated.
		> m3llet	, MD		027	211		12.1	_	2009
10x		30. Name and address of person who completed cau Stwan Billet, MD,	se of death (Item 2	23a) (Type, F	getom b	W, E	dessb	449	MD	21784
Stat Registra		31. Date filed (Month, Day, Year) 32.	egistrar's Signatu	re L	0.06.1	t				
MH 17 Rev 7/20		2 2 1 2000	num p	6 8						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#30perDVR, G898, 12/17/09, WS
State of Maryland / Department of Health and Mental Hygiene 200 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da Z **Physician** VIN 87 NO 200 12 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baitimore Kandailstown Hospice 16. Sex orthwest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days -8388 1 M 2□ F laryland Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Honor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black δ 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) 12 man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be venia lliam 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number State, Zip Code) Whita 2030 Kez-daughty Tree t It more M 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 19/09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) mD sardens of Faith 21. Signatur A Funeral Service Licenses 22. Name and Address of Facility Brehms 21213 timore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mus ) /Medical **Examiner** 5 mos Mo Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 🗆 No 1 ☐ Yes Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 ☐ Yes 2 **N**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A 2 Accident the 6 ☐ Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd. Karen Merritt Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2009 1 Registrar

09-08486 Ste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

ephanie West	1-	State of Maryland / Department of Health and IME For State Certificate of Death	Reg. No. 2009 402
Physician	Re	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year November 2, 2009  3. Time of Death 0250 hrs
edical Examin	er	Stephanie Lynn West  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location	
;	4	1440 Fidler Lang Apt 703 Silver Spring	Montgomery  Juder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		5 Social Section Number 10, Sex 17, Age (11) 10, 1867 11, 1867	ours Min. 04/12/1965 Virginia
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<b>*</b> *		10a. State DC Washington	1 Yes 2X No
the Maryland a or 28a-f show tified at once.		10e. Street and Number S.W. 10f. Zip Code 4001 Martin Luther King Jr. Ave 20032	USA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	- I	11. Marital Status  1 X Never Married  2 Married  1 Yes 2 X No	white, etc.
rs after ural",	ᇍ	or Dates:	Give kind of work done 16b. Kind of Business/Industry
136 hin 72 hour e. than "natr edical Exar	pleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Unknown
21215-0036 uld be filed within ? Mental Hygiene. marked other than c event, the <u>Medica</u>	$\sim$ 1	18.M	nother's Name (First, Middle, Maiden Surname)
121 Id be fi Jental	a B	100 Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and	d Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 Id 2 shou' lith and M m 27 is n aumatic		Kim West-Scott   1206 Stage Co	oach Rd., Nathalie VA 24577
E B E E		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemeter crematory or other place)  West Family Cem.	11-06 ²⁰⁰⁹ Nathalie VA
Baltimore, permit. Pages 1 a Department of He Important: If He		21. Sign tur of Funeral Service Licensee  22. Name and Address of Jeffress F	Facility Brookneal VA 24528 Cuneral Home 304 Lusardi Dr.
Physician		23a. Pay I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc	ch as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
'Medical		fallue. List only one cause on each line.  Immediate Cause (Final disease a. Diabetic ketoacidosis	Death
taminer		or condition resulting in death)  Due to (or as a consequence of):	
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
ed nsit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	
iO, ce be executed ysician and burial - transit	lical	XUNPENDED AMENDED 23a,PII,27,permE, g898	12/21/09_TT
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi			Ectopic pregnancy 23d. Date of delivery  Month Day Year
Box death he atter	ysic	1 Yes 2 No 9 V Unknown g Unknown	en in Part I. 23e. Did tobacco use contribute to the cause of death?
D.O. that the red by t	by P		1 Yes 2 No 3 Probably 4 ✔ Unknown
rds, F requires been sign	Completed I	Chronic alcoholism	24a. Was an autopsy findings available prior to completion of cause of death?
eco he law ate has	d Wo		1 ✓ Yes 2 No 1 ✓ Yes 2 No
ian: Trans. Tectific	Ba Ba	25. Was case referred to medical	of Death (Check only one)  ther;  Nursing Home 5 Residence 6 ✔ Other: Scene
f Vit Physic er this c	[2	1 V Yes 2 No Imparent 2 Electrostation	
nding th.	 	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury 1 X Natural 5 Pending	es 2 No
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office but (Specify)	ilding, etc. 28f. Location (Street and Number or Rural Route Number, Ci or Town, State)
he Hospit in 24 hour he Fuaer:	cal Ce		e and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s)
To t With To t	Medical	and manner stated.  29c. License	number 29d. Date signed (Month, Day, Year)
		O.C.N	
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltim	pre, MD 21201
	Stat	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regi		ORICINAL ORICINAL	
DHMH 17 Rev 1	/200	JI OOME ORIGINAL	

09-09619 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph L. Abbott, Sr. 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day December 10, 2009 0000 hrs Medical Examiner JOSEPH ABBOTT, SR. L. 4c. County of Death 4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Somerset 700 Norris Harbor Drive # 110 Crisfield 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreian Months Days Hours Director Country) Maryland 214-42-9354 06/08/1944 1 X M 2 65 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10b. County 1 X Yes 2 No Crisfield Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 78a-f cho. Maryland Somerset notified at once. Director 10f. Zip Code 10g. Citizen of What Country' 10e, Street and Number 21817 U.S.A. 319 Somers Cove Apartments Ē 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X No Yes White 1 Yes 2X No specify: Specify. 3 Widowed 4 X Divorced If Yes, Give Year ò 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpentry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellestine Nelson Frankie W. Abbott 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21838 Wenona Matthews (Sister) 5921 Cornstack Road - Marion Station, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State 12/12/09 Delmar, DE Crematory of Delmarva Donation 5 Other Speci 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, Bradshaw Robert Approximate Interval hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Part I. Enter the disease, or complicative Between Onset and failure. List only one cause on each /Medical Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ending physician and use as the burial - transit Physician/Medical AMENDED 23a,27,28a-f,perME, g899 1/8/10 TT X UNPENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been a director, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: The 26.Place of Death (Check only one) of Vital 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes မ 2 No 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Director: Pending unk Fd 12/10/09 Fd 2:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 700 Norris Harbor Dr. #110 Crisfield Dr filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined (Specify) found at home To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

Medical

State

29b. Signature and title of certifie

Jack Titus MD.

31. Date filed (Month, Day

and manner stated

Deputy Chief Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 11, 2009

		_ For				id / Dep	ndelible Ink artment of I	Health	and Mer	-		_		- 1 -
		State     Registrar  1. Decedent's Name (First, Middentification)	le, Last)			Ce	ertificate of	Death		Date of Dea	leg. No.	2009	3. Time o	2 4 2
Physicia /Medic	al	Eric Maria  4a. Facility Name (If not institution		nann	rl		4b. City, Town, c	r Location	De	Month ecembe	7	Year 2009 County of Death	2:20	P ^M
Funeral Director		952 Fricks Cr. 5. Social Security Number 296-26-1724 Usual Residence of Decedent	6. Sex	ng Road		last birthday Yrs.	0aklan	d	r 24 Hrs.   8. (	Date of Birth (Month, Day an. 19	G Year)	arrett 9. Birth Cou		or Foreign
aryland show	5	10a. State 10b. County				ty, Town or L							10d. Inside C	City Limits
h the M or 28a-f	Director	MD Garre	tt		0	akland	10f. Zip Code			1	I0g. Cit	izen of What Cou		, 2 24110
urs after death w II", or Items 23a	by Funeral	952 Fricks Cro	ried 1	2. Was Deceden Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates	2 No	.S. 13.	21550 Was Decedent of Hif Yes, specify Cub 1 Yes 2 XNo	Hispanic Or an, Mexica Specify		Yes or No- n, etc.)	Uni	ted Stat  14. Race - Ameri Black, White,  Specify:	can Indian,	
ithin 72 ho ne. nan "natur Medical!	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Educa	College (1-4or	5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	durina mos	st of working		16b. Ki	ind of Business/In		
1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than wher traumatic event, the Ma	Be	17. Father's Name (First, Middle		5	-	Own	er		ner's Name (Fin		Boa Maiden			
should nd Mer marke	၉	Rolf M. Ammanr		e. Print)		19b. Mail	ing Address (Street		garet V		r. City o	or Town, State, Zi	o Code)	
and 2 sealth a n 27 is		Mary Ammann, V					Fricks C						•	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		emoval from State	#		osition (Name of ematory or other pla and Cremat	- ;	Date 12/06/	2009		berland,		
permit. Depart Import any inji		21. Signature of Funeral Service	License	weiter			2. Name and Addre	ss of Facili	lity			me, P.A. MD'21550		
Physician /Medical Examiner		23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	complic only one a. b.	Due to (or a	s a conseq	Uence of):	//	ng, such as	s cardiac or re-	spiratory ar	rest,	2.	Approxima Interval Be Onset and	te etween Death
pricis pe	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	Due to (or a		·								
The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	ic. If yes, outcom  1  Live birth 4  Pregnant 9  Unknown	2 Feta	death 3	☐ Ectopic pregnand	су				23d. Date of deliv	ery Day	Year
res ti	2	Part II. Other significant condit	One cont	ributing to death	but not res	alting in the	underlying cause giv	gin in Part	l.			use contribute to t		death?
: The law recate has be page 2 sho	Completed									24a. Was a autop perfor	sy	death?	opsy findings ompletion of	
ician certifi ector	Re	25. Was case referred to medical examiner?	-	ospital:			ont 3 🗆 DOA Oth		e of Death (Cl	neck only or	ne)			
ding Phy th. After this funeral d	0 : To	1 Yes 2 Ne. 27. Mappier of Death		1 ∐ Inpa 28a. Date of In (Month, D	jury	28b. Time Injury	III 3 DOA	4 L N		5 Pesid Describe h		6 ☐Other (Special of Control of	fy)	
Attending er death. rector: Afte by the fune	Certification	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	gation not be	28e. Place of Ir		ome, farm, s		lYes 2□	28f.	Location (S		nd Number or Rur	al Route Nu	mber,
		29a. Certifier  (Check only 2   Medica	ng Physi	clan: To the bes	t of my kno	wledge, dea	ith occurred at the ti	me, date a	and place, and	due to the	cause(s	s) and manner as	stated.	(a)
the H thin 24 the F omplete	Medical	one) 29b. Signature and title of ordific		and manner s	stated.	allott allu/of t	29c. Licens					te signed (Month,		(5)
F > F 2		1 /20	/	nnlatad as	dogth "	225\ /7	D	23979				2,47	Juj, real/	
		30. Name and address of dersor Robert A. Go					Street, (	Dakla	nd, MD	21550	)			
Stat Registra		31. Date filed (Month, Day, Year		32. Regis	trar's Signa	ture								
HMH 17 Rev 1/20		DEC - 8	200	Jones	-	p. A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registra Certificate of Death 1. Decedent's Name (First, Migdle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1601 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Bowie 16321 Abbey Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Months Hours Washington, DC August 17,193 Director 577-40-2062 Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 USA 16321 Abbey Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrator Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Joseph McDermott Sophia Deck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16321 Abbey Drive Bowie, MD 20715 William R. Atkins/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/4/2009 Mt Olivet Cemetery 4 Donation 5 Other (Specify) Washington, DC . Signature of Fu. er 22. Name and Address of Facility Robert E. Evans Funeral Home Bowie, MD 20715 16000 Annapolis Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death. shock, or heart failure. List only one cause on each line Immediate Cause (Final BLADDER Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar w

a

31. Date filed (Month, Day, Year)

DEC 01

NEVENSE

			State of Maryland / Departm  1- State Registrar Certific	ent of He	alth and M eath	ental Hygid	ene 2009	40244
į.			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
P	Physici /Medic		William H. Atkinson			Month N <b>ovem</b> ber	29, 2009	5:45 a M
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. 0	-	ocation of Death		4c. County of Death	1
	in the same of the same of the same of		Collingswood Nursing & Rehab.	Rockvi		0.7.		gomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U		Hours Min.	8. Date of Birth (Month, Day, 1	Year) 9. Birth Con 1918 Mary	nplace (State or Foreign untry) 11and
	ъ		Usual Residence of Decedent					101 1-11-07-11-1
	show show	'n	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 No
	the N 28a-f notifie	Director	Maryland Montgomery Potom  10e. Street and Number 10f	nac f. Zip Code		100	g. Citizen of What Cou	untry?
	n with	Ö	8209 Jeb Stuart Road	20854			USA	,
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D Armed Forces? 13. Was D	Decedent of Hisp	anic Origin? (Spe Mexican, Puerto F	cify Yes or No-	14. Race - Amer Black, White	
36	e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	by Fu	1 Never Married 2 X Married 1 XYes 2 No	_	Specify:	,,	Specify: Wh:	
21215-0036	2 hour atural	ed b	15. Decedent's Education 16a. Decedent's	Usual Occupation	on	1	6b. Kind of Business/I	ndustry
215	hin 72 9. an "na Medik	Completed	(Specify only highest grade completed)   (Give kind o	of work done dur OT use retired)	ring most of workin	g		,
	ed wit ygiene er the	Com	4 Speci	al Agen			FBI	
Maryland	be fill ntal H ed oth even	Be	17. Father's Name (First, Middle, Last)  Kirkwood Atkinson	1:	8. Mother's Name	(First, Middle, M. Sophie I	ŕ	
$\frac{8}{2}$	thould and and and and and and and and and an	으		dress (Street an			City or Town, State, Z	in Code)
	nd 2 saith ar aith ar 27 is r trau			*			MD 20854	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Ze,	es 1 a of Hea ittern rothe		20a. Method of Disposition  20b. Place of Disposition  20b. regression cemetery, crematory	or other place)	Dog		0c. Location - City or	Γown, State
Ē	Page ment ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heav	ren Ceme	tery Dec.	09' 5	Silver Spr	ing, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee  22. Nam 500	ne and Address Incis J. Univers	of Facility Collins ity Blvd	Funeral	Home Inc.	ng, MD 20901
	<b>4</b> 0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying,	such as cardiac or	respiratory arres	st,	Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition resulting in death)	o the	ive			Onset and Death
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	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				75	
>	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.					
Ö,	cate be executed physician and the burial-transit	Exc	resulting in death) Last Due to (or as a consequence of):					
8760,	cate b	dical	d					
Box 6	he law requires that the death certificate has I een signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23d. Date of deli	verv
	death e atte	sicia	in the past 12 months?	pic pregnancy er <i>(specify)</i>			Month	Day Year
P.0	at the	Phys	9 Li Unknown		to Book I	OO- Did tob		Abo access of death?
Records, P.O.	w requires that s I een signed b s should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the	ing cause given	in Part I.	23e. Did toba	acco use contribute to s 2 <b>2</b> No 3 □ Pro	
Sor	requ leen shoulk	etec				24a. Was an	~ -	topsy findings available
	sician: The law	Completed				autopsy perform	prior to o ed? death?	completion of cause of
Vital	an: I	Be C	25. Was case referred to medical		26. Place of Death		XINo 1 ∐Yes	2 No
<u>-</u>	Physic this ce al direc	To B	examiner?  1 Yes 240 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other:			nce 6 Other (Spec	cify)
Division or	Attending Physician: r death. ector: After this certification the funeral director, i		27. Manner of Death 1 Manuary S □ Pending 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury a Work?		8d. Describe how	v injury occurred	
Sio	death.ctor: /	icati	2 ☐ Accident investigation M 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa		es 2 No	8f Location (Stre	eet and Number or Ru	iral Boute Number
<u>≤</u>	after after I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	etary, amou		City or Town,		rai riodie ranibei,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a. Certifier (Check only (Check only (1) Medical Examiner: On the basis of examination and/or investig.	urred at the time	, date and place, a	and due to the car	use(s) and manner as	stated.
	the H hin 24 the F mplete	Medical	and manner stated.					
	- 1	<	29b. Signature and title of certification (MD)	29c. License r			d. Date signed (Month	
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	(33	0 :	11/30/	
			SAYED EISATYA'D 10110 Ma	eleluli	ar Br.	Kock	ulle, MC	2009
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	3		· ·		
	Registr	ar	DEC 02 2009 Senera B. garles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 28, 2009  $\mathbf{P}^{\mathsf{M}}$ PETER CHRISTIAN **ANDRESEN** 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3219 University Blvd., West Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Days 1 XM 2 ☐ F 578-44-2592 74 Oct. 16, 1935 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3219 University Blvd., West 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No POST-If Yes, Give Year or Dates+KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Owner & Operator Law Firm marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 is marked any injury or other traumatic every William A. Andresen Doris Schlegel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol G. Andresen/Wife 10416 Fawcett Street, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Dec. 2009 Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licen Spring, MD 20901 uch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ATHEROSCLEROTIC CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPERCHOLESTEROLEMIA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Tes 2 No 3 Probably 4 Unknown DIABETES MELLITUS TYPE II page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 1 ♣ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: filled in by the funeral director, 24 hours after death • Funeral Director:

death with the Maryland

Baltimore, Maryland 21215-0036

To the Hosp within 24 hor To the Fune completely f

State Registrar

Medical

31. Date filed (Month, Day, Year)

DEC 02

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

MICHAEL P. VILLAROMAN, M.D., VAMC, 50 IRVING STREET NW. WASHINGTON.DC 20422/688 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number MD# 34028 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DECEMBER 1, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 24, 2009 1:50 PM SHIRLEY B. BRIDGES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21320 PHILLIPS ROAD TILGHMAN TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗙 F Days Hours MARYLAND JUNE 6, 1934 Director 217-36-2147 75 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Experimer must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1XYes 2 No Directo TILGHMAN TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21320 PHILLIPS ROAD 21671 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE 2 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELEANOR SINCLAIR EDGAR B. McCLURE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE A. BARRETT/DAUGHTER 7459 SOLITUDE LANE, ST. MICHAELS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State SHERWOOD CEMETERY 12/01/2009 SHERWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Puneral Service 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a Solution in the disease or complications that caused the death. Do not enter the mode or lying, such as cardiac or respiratory afress. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mo~17/1 deno CACCINOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Dav 5 Other (specify) 1∐Yes 2⊿No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 LUDWIG J. ÉGLSEDER, III 503 CYNWOOD DRIVE, EASTON, MD 21601

DHMH 17 Rev 1/2001

State Registr<u>ar</u>

Denne A. park

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	aryland / Dep Cea	artment of H rtificate of D			iene _{eg. No.} 2009	40247
	DI	,	Decedent's Name (First, Middle)	e, Last)				2. Date of Deat	h	3. Time of Death
	Physicia Medio		Russell Gordo	n Brown Sr	•			Orcemb	cr Day 200	9 10:01 M
y - May	Examin	er	4a. Facility Name (if not institution	, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Dea	th
			Washington Cou			Hagersto			Washingt	
ı	Funeral Director		5. Social Security Number 217–30–6104	6. Sex 7. Ag	e (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 29	Year) 9. Bi	rthplace (State or Foreign ountry) yland
	nd how	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation		-		10d. Inside City Limits
	faryla 3a-f s tified	Director	Maryland Washi	ngton	Uncorot	0.577				1 🗆 Yes 2 🗷 No
	or 2		10e. Street and Number	ngton	Hagerst	10f. Zip Code		1	0g. Citizen of What C	
	with s 23a ust b	Funeral	11405 Lakesid	e Dr. Lot #	5	21740			U.S.A.	ŕ
	death items		11. Marital Status	12. Was Decedent E Armed Forces?	ever in IIS 13 1	Was Decedent of His	panic Origin? (Sp	ecify Yes or No-	14. Race - Am	
38	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 Never Married 2 Man 3 Widowed 4 Divorced	nied 1 ∐ Yes 2 ☑ If Yes, Give	<b>W</b> o	f Yes, specify Cuban 1 ☐ Yes 2 🗖 No	Specify:	rican, etc.)	Black, Whit	
0-0	hours natura ical E	Completed	15. Deceder	nt's Education	16a, Dece	dent's Usual Occupa	tion	- 1	16b. Kind of Business	ite
215	in 72 e. ian "r Med	鬞	(Specify only higher Elementary/Seconday (0-12)	est grade completed)  College (1-4 or 5	(Give	kind of work done du O NOT use retired)	uring most of work	ing	Paint	illoustry
7	ygien gien yer th		12	January (1 1 01 0		Maintena	ance		Manufactu	ring
pu	e filed Ital Hy ed ott	To Be	17. Father's Name (First, Middle, L	ŕ				e (First, Middle, M	faiden Surname)	
Z	d Mer d Mer mark natic	-	Charles E. Brow				Faye E		own) Brown	
Maryland 21215-0036	2 shouth and the shou		19a. Informant's Name/Relations		· ·				City or Town, State, Zi	•
ē,	Heal Heal Item		Pamela J. Shelt 20a. Method of Disposition		20b. Place of Dispo				L11e, WV 2	
Baltimore,	age ent o	-	1 ABurial 2 Cremation 4 Donation 5 Other (S	3 Removal from State		natory or other place	)		•	,
alti	permit. F Departm Importa any inju		21. Signature of Funeral Service L			en Cemeter  Name and Address	of Facility Roc	:/2009    - -t Hayen	<u>lagersto</u> wn Funeral Cl	Maryland
m	a la		> SMark.	Sum						aryland 21742
П			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not ente					Approximate Interval Between
2	Physician/		Immediate Cause (Final disease or condition	Carle		t du	o to A	(3/4/)	. 4	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	ellity	200	0110	-	- none accord
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	ed	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):		1.		J.	
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8760	tificate ng phy as th		IF FEMALE:							
x 68	tendir r use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth		Ectopic pregnancy	,		23d. Date of de	livery
Box	v requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)	<u> </u>		Month	Day Year
0.0	hat the		Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O.	uires t	ed by						1 □ Ye	s 2 🗆 No 3 🗆 F	Probably 4 Unknown
Sorc	iw required sales	Completed						24a. Was an		topsy findings available
Rec	sician: The law certificate has k irector, page 2 s	ĕ						autops perforn 1  Yes 2	ned? death?	completion of cause of s 2 \( \subseteq \text{No} \)
ta	cian: ertific sctor,		25. Was case referred to medical examiner?			26. Plac	ce of Death (Chec			3 2 3 110
Ξ	Physic this o	၉	1 Ves 2 No		ent 2 K ER/Outpatier	1	4	me 5 Reside	nce 6 Other (Spec	cify)
0 0	ding Phys h. After this funeral di	Certificate:	27. Manner of Death  1 Natural 5 □ Pendin		ry 28b. Time of injury	work?		28d. Describe how	w injury occurred	
sio	Attendii r death. ctor: Af y the fu	rtific	2 Accident Investig	not be 28e Place of Inju	ıry - At home, farm, stre		′es 2□No	28f Location /Str	eet and Number or Ru	umi Poute Alumber
Ö₹	al or / s after il Dire		4  Homicide determ	building, etc	. (Specify)	out ractory, office		City or Town,		rai noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 \subseteq Medical E	Physician: To the best of xaminer: On the basis of ex	kamination and/or invest	tigation, in my opinion	. death occurred a	the time date and	place and due to the	cause(s) and manner stated
	the lithin 2 the lomple	Me	only one) 3 Certifying 29b, Signature and title of certifier	Nurse Practioner: To the	best of my knowledge, o	death occurred at the	time, date and plac	e, and due to the	cause(s) and manner as	stated.
	F > F Z		In was to a	R. C) NI	_	29c. License	1800	29	d. Date signed (Mont	
			30. Name and address of person v		eath (Item 23a) (Type F					
	6		Mussoud Ri	Lizadehi	MO 240	Frederic	ic St A	tagersto	wh, MA .	1740
	Stat		31. Date filed (Month, Day, Year)	32. Registra	eath (Item 23a) (Type, F MO 240 Ir's Signature	d		0		
	Registra	ır	APA 9 1 50	1	0					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 1, 2009 **Physician** 14:05 DONALD R. BLACKA, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND WMHS - RMC Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 X M 2 ☐ F 234-78-7944 Antioch, 16,1948 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director New Creek 28a-f WV Mineral 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26743 USA , or items 23a HC 75, Box 67-A by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Yes Give Specify. 3 ☐ Widowed 4 💆 Divorced White Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, tra Manany injury or other traumatic event, tra Manan Elementary/Secondary (0-12) College (1-4or 5+) Trash Disposal Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ella Woods Donald R. Blacka, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26743 New Creek, WV Maggie Blacka/ Daughter P.O. Box 70 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 11 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 2009 Cumberland, Maryland The Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licenses Smith Funeral Home Duew 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cardionamon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0066101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEEMA, ABDUL H., M.D., 12500 WILLOWBROOK ROAD, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 40249 1 - State Registrar #20b, TCHD, 11/30/2009, TLS Amended #16b. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ( Month 12/7PM William Ε. Bonsteel byember 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memoria Easton lalbot If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours 10-15-1931 Months Director 269-28-8473 78 Ohio Usual Residence of Decedent 28a-f shov and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Talbot 1 Yes 2 No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7671 Tred Avon Circle 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of *** Vergment 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. Government Elementary/Seconday (0-12) College (1-4 or 5+) FEMA Executor Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Kibourne Bonstee] Ruth McKee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bonsteel/Wife 7671 Tred Avon Circle, Easton, Md. 21601 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State  $11-30^{-12009}$ cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Direct Crematory 4 Donation 5 Other (Specify) 12-01-09 Dover, De. 22. Name and Address of Facility Bennie Smith Funeral Home Signature Funeral Service Licensee 426 Dover Street, Easton, Md. 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between GRAM NEGATIVE BACTEREMIA Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions Examiner Duri to for as a consequence of If any leading to immedicause. Enter Underlying Cause (Disease or iinjury LUNG CANCER Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? After this certificate 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jun Botser D0059487 11-26-2009 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1+VA John Botsis.M.D. EastowMd.21601 219 Washinton St 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 40250 amend 8 per Dr. g898 12/10/00/ficktie of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Bay Year **Physician** BELGARD, 08:33A M BABY 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE, MARYLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11/28/09 NONE Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director MONTGOMERY KOCKVILLE, MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 KNOLL ERRACE USA death 1 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other there any Injury or other traumant. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Şecondary (0-12) College (1-4or 5+) INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BELGARD ANN BINDEMAN Julie NATHANIEL ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 OAK KNOLL TERRACE. BELGARDI MOTHER Kockviller MD 20850 JULE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STERI CYCLE HALL RIVER, NC 12 28/2009 22. Name and Address of Facility SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, Md 20850 23a. Part1. Enter the disease, or shock, or heart failure. Lis complications that caus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, PREMATURITY Immediate Cause (Final disease or condition resulting in death) XTREME **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**X**No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury n 24 hours after death.
The Funeral Director: After the funeral part of the funeral pa 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one)

State Registrar 29b. Signature and title of certifier

SADEKA JUDE,

DHMH 17 Rev 1/2001

within 24

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32 Registrar's Signature

buch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Registrar		C	ertificate of	Death	F	Reg. No. 2	19 4025					
Physician	1. Decedent's Name (First, Middle, Last)  Betty Lou Baker					2. Date of Dea Month DECEMBE	Day Ye	3. Time of Death					
/Medical Examiner	4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of						
	Reeder's Mem				onsboro	T - 0 - 1814		shington					
neral ector	5. Social Security Number 217–30–6293	6. Sex 7. Age 1 M 2 <b>X</b> F	(In yrs. last birthda 74 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 22	h, Year) , 1935	Birthplace (State or Foreig Country) Maryland					
10	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits					
or other traumatic event, the Medical Examinar must be notified at  To Be Completed by Funeral Director	Maryland Wash	ington	S	Sharpsburg				1x Yes 2 □ No					
Dire	10e. Street and Number	,		10f. Zip Code			10g. Citizen of Wha	at Country?					
la	204 East Mai		- : 110		21782		44 8	USA					
by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	verin U.S.	3. Was Decedent of H If Yes, specify Cub 1 □Yes 2X No	an, Mexican, Puert	o Rican, etc.)	Black, \ Specify:	American Indian, White, etc.					
Completed	15. Decedent (Specify only highes		16a. De	cedent's Usual Occup	pation	kina	White 16b. Kind of Business/Industry						
ag m	Elementary/Secondary (0-12)	College (1-4or 5+	) life	ve kind of work done  DO NOT use retire		King							
	9 17. Father's Name (First, Middle, 1	ast)		Ribbon Ro	1	ne (First Middle	Ribbon M Maiden Surname)	anufacturer					
To Be	John Webster				Marv		e Fisher						
-	19a. Informant's Name/Relationsh		19b. Ma	ailing Address (Street									
	Carolyn Shaw-P	R											
	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 🗆 Removal from State	20b. Place of Dis cemetery, of	position (Name of rematory or other pla	ce)	Date	20c. Location - Cit	ty or Town, State					
	4 □ Donation 5 □ Other (S)	pecify)					Smithsbur	g, Maryland					
9000	21. Signature of Foneral Service	Licensee	I	Sbottie fu		-	illiamana	mt MD 21705					
	23a. Part 1. Enter the disease, or	complications that caused t	the death. Do not				-	rt, MD 21795 Approximate					
in ai	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. MASS	3106	STROKE	£			Interval Between Onset and Death WEEKS					
r				<del>}</del>			Due to (or as a consequence of):						
100	Sequentially list conditions, and an accompany to the following to the fol						IVIONITIES						
_ =	Sequentially list conditions, in any, leading to immediate	200 to (0) de d	consequence of):					MONTHS					
amine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						MIONTHS					
al Examiner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					MONTHS					
	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		,				MONTHS					
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To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner?  1   Yes 2   No 27. Manner of Death  1   Natural 5   Pending investig 2   Accident 3   Suicide 6   Could not work that it is not past 15   Suicide 6   Could not past 15   Could not past 2   Suicide 6   Could not past 2   Could not past 2   Suicide   Suicide	Due to (or as a d.  23c. If yes, outcome of the little birth 2 death but t	of pregnancy Fetal death time of death t not resulting in the	3  Ectopic pregnants 5 Other (specify) = 9 underlying cause given tient 3 DOA Otto 1 28c. Inju 9 M 1	ven in Part I.  26. Place of Deaner: 4 A varsing H	24a. Was a autop perfor 1 Yes ath (Check only or lome 5 Resid	Month obacco use contribu fes 2 No 3[ an 24b. We pric dea 2 No 1 ne) dence 6 Other now injury occurred	of delivery  Day Year  ute to the cause of death?  Probably 4 Unknow  re autopsy findings availably or to completion of cause of atth?  Yes 2 No  (Specify)					
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State of Maryland / Department of Health and Mental Hygien 2000 0

			For State Registrar	State of Marylar			nt of Healt <i>te of Dea</i>		ental Hygie Reg.	m 0 0 2	40252	
	Physici	an	1. Decedent's Name (First, Middle, Las	"Naoni B 1	305-1	HON		2	2. Date of Death Month	Day 24 Year	3. Time of Death	
}	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, or Local	tion of Death	D	4c. County of Dea		
	Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year								er 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign			
	yland	ector	Usual Residence of Decedent							10d. Inside City Limits		
	the Mar 28a-f st		10a. Street and Number 34544 Rapload Ave. 21850					Citizen of What C	1 Yes 2 No			
36	23s or	rai Dir	3454	14 Raplnoad	Au	P. 5	21850		Tog.	W; con	,	
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23s or 23s-f show any injury or other traumatic event, the Medical Examinational Es multiled at ODGs.	To Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S.	13. Was Dec	edent of Hispanio ecify Cuban, Me: 2 X No Spe	c Origin? (Spec xican, Puerto R ecify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi		
2-00	"natura		15. Decedent's Ed (Specify only highest gra-	ucation	1 1	Give kind of w	uaf Occupation ork done during	most of working	168	. Kind of Business		
212	d withir		Elementary/Secondary (0-12)	College (1-4or 5+) 5+		iite. DO NOT EKG tec	hnician			hospit	al	
Baltimore, Maryland 21215-0036	ld be file enta! Hy ked oth Ic event		17. Father's Name (First, Middle, Last)  Gustaf Peterson				18. N	Naomi I	(First, Middle, Mai King	den Surname)		
	ind 2 shou alth and M 27 is mar ir traumati		19a. Informant's Name/Relationship (7 Elizabeth Robert			is (Street and Number or Rural Route Number, City or Town, State, ailroad Ave., Pittsville, MD 21						
	Pages 1 a ant of Hea nt: If Item y or othe		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery	Disposition (Na r, crematory or	ame of other place)	Da 11/27		Location - City o		
Baltir	permit. F Departme Importan any injur	1	1. Sign, ture of Funeral Service Licen	see		7				alisbury ssional	Association 804	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	ofications that caused the dea							Approximate Interval Between	
	Physician /Medical		fmmediate Cause (Finaf disease or condition resulting in death)	a. ASCVD							Onset and Death	
	Examiner	늗	Sequentially fist conditions, if any, leading to immediate	Due to (or as a consequence of): b								
68760, ilicate be executed physicien and	cuted id ansit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								
	ficate be executed physicien and s the burial-transit		resulting in death) Last	c. Due to (or as a consequence of): d.								
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date of de	23d. Date of delivery		
P.O. B	the deal by the att ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)				Month Day Ye		Day Year		
	quires that an signed build be det	To Be Completed by	Part If. Other significant conditions of Disbettis Mellitu	ions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vinknown				
Reco	8 0		Hyperterion,							autopsy prior to completion of cause of death?		
Division of Vital Records, i or Attending Physician: The law requires taller death.	sician: certific rector,		25. Was case referred to medical examiner?	ical 26. Place of Death (Check only one)								
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page		1 Yes 2 Ho  27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury			30 DOX 40 INDISTINGUISE 30 ABS			sidence 6 (Other (Specify) e how injury occurred		
Divisi	ai or Atter s after dea ni Director	Certification:	3 Suicide 6 Could not be determined	6 390 Place of Injury At home form street feature #Fire					reet and Number or Rural Route Number, , State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check orly) one  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							as stated. ue to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	J			9c. License num		29d	Date signed (Mor	nth, Day, Year)	
,	Dal		30. Name and address of person who	completed cause of death (Ite	m 23a) (		-		100 2	[24/03		
	Sta	to.	30. Name and address of person who CGES/4 V 0 14 RA 31. Date filed (Month, Pan, Year)			Lacks	SAL	ISB UFT	, MU, 21	804,		
	Registi		UEC 012	32. Megistrar's Sign	D.	park						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40253 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 2009 **Physician** Walter H. Beverly, Jr. 3:15 P M November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Ridge Assisted Living Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 XM 2 □ F 92 015-05-8512 oct. 21, 1917 Maine Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Director Westminster 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 High Acre Drive 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No 1942— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) branch supervisor Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter H. Beverly, Sr. Mary Petersen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2815 Brougham Court Manchester, Maryland 21102 Dale C. Buckingham - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State Date Nov. 30, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, Maryland 4 Donation 5 Other (Specify) 2009 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) armour /Medical Due to (or as a consequence of) Examiner yperlype Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to fiedical examiner?
1 ☐ Yes 2 ☐ Wo Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation hours after death.
uneral Director: A death. 1 ☐ Yes 2 No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MJL 0 V0050163 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRNESO 82C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0EC 0 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 10d per F. D. 11/30/09 Carroll County, will

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 9:45 p George Ernest Brunst November 26, 2009 /Medical 4a. Facility Name (If not institution, give street and number Health Care 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Lutheran Village Center Westminster 8. Date of Birth (Month, Day, Year) Jul 5, 192 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2□F Ohio 1922 87 291-16-6212 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Carroll Westminster Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 2390 Uniontown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ò WWII 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of Rose Tomasek Emil Brunst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2390 Uniontown Road, Westminster, MD 21158 Jerry L. Brunst, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Injury or 12/02/2009 Solon, Ohio Roselawn Cemetery 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses 91 Willis Street, Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pearo **Physician** /Medical to for as a consequence of) **Examiner** Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed as the burial-trans and Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician the detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 2 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 9□Unknown 9 TUnknow 23e. Did tobacco use contribute to the cause of death? trivuit g to really but not resulting in the underlying cause given in Part I. Part II. Other si Division or Vital Records, **p** 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Nursing Home 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) P To the Hospital or Attending Ph, within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation Matural 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WSL 6+114 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sac NOV Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /		rtment of H tificate of L			giene Reg. No.	2009	40255			
	Physici	20	1. Decedent's Name (First, Middle	e, Last)	-				2. Date of Dea	ath Day	Year	3. Time of Death			
	/Medic		Ruby Marie B	ingel					Novemb	er Z	27 2009	0500 ^M			
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. (	County of Death				
			3315 Augusta 5. Social Security Number		e (In yrs. last bi	(reth do. a)	Manch If Under 1 Year	Carrol Right							
	Funeral Director		216 <b>-</b> 20-7066	1 M 2 M 2 M F	84_	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Aug 13	y, <i>Year)</i> 192		place (State or Foreign ntry)  MD			
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Loca	ation				1	0d. Inside City Limits			
	Maryl	tor	MD Car	roll	Ma	anche	ester					1 ☐ Yes 2 XNo			
	or 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	ntry?			
	th wit	ral	3315 Augusta	Road			2110	)2		Ţ	JSA				
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Modical Eventiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 點 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2 □ X If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba □Yes 2 <b>∏n</b> \io	ispanic Origin? (S n, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)		4. Race - Americ Black, White, Specify: Wh				
2-0	72 ho natur tical	eted	15. Decedent (Specify only highes	's Education	168	a. Decede	ent's Usual Occup- ind of work done of O NOT use retired	ation during most of work	kina I	16b. Kin	d of Business/In	dustry			
121	vithin ene. <b>than "</b>	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)				)-11 7L1						
2	filed v Hygie other t		17. Father's Name (First, Middle, I	Last)		- 2	Superviso	18. Mother's Nam	ne (First, Middle,		<u>Bell Atl</u> Surname)	antic			
an	thould be filed withir and Mental Hygiene.  marked other than matic event, the Market	To Be	William Swob					Ruby I	•		,				
ary	shoul tnd M mari umati	Ĕ	19a. Informant's Name/Relationsh	nip (Type. Print)	19	b. Mailing	Address (Street			er, City or	Town, State, Zip	Code)			
Ž,	and 2 s fealth an m 27 is her trau		William C. Bin	gel/son	1	L020	Beggs Ro	ad West	minster	, MD	21157				
ore	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2	20b. Place o	of Disposi ery, crema	ition (Name of atory or other plac	e)	Date	20c. Loc	cation - City or To	own, State			
Ë	Pages trant of tant: If ite jury or o		4 □ Donation 5 □ Other (S)		Lorra	ine	Park Cem	11/3	0/2009	Balt	imore,	MD			
Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe		21. Signature of Funeral Service I	Licensee			Name and Profes								
	40 <b>2</b> 10 G		22a Part Enter the disease or	complications that caused	the death Do		.2 Washin				er, MD	21157			
- Par	Physician		23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
1	/Medical Examiner		,	Due to (or as	a consequence	of):	Den:					1210			
		ier	Seque fliany list conditions, if any, leading to immediate cause. Enter Underlying	Due to (a) as	a consequence	of):	Service Contraction	4	UNITED STATES		_	10 yu			
	cuted nd ransit	Examiner	that initiated events	c											
, 00	rificate be executed g physician and as the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence	of):									
68760,	physic the b	edical		d							-				
	certifi nding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					12	3d. Date of deliv	erv			
. Box	that the death certified by the attending detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ NO	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnancy Other (specify)	<i></i>			Month	Day Year			
P.O.	at the by the tache	hys	9 🗆 Unknown	9 🗆 Unknown											
	es tha igned be de	by F	Part II. Other significant condition	ns contributing to death be	ut not resulting	in the und	derlying cause give	en in Part I.				he cause of death?			
ord	requir een s nould	ted							1 🗆 \	/es 2 🛚	PTNO 3 Pro	bably 4 🗆 Unknown			
3ec	elaw hasb e2st	Completed							24a. Was		24b. Were auto prior to co death?	ppsy findings available impletion of cause of			
alF	n: The ficate r, pag								1 □ Yes	2 410	1 ☐ Yes	2 □ No			
Ζ	sicial certii irecto	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ⚠ No	Hospital:	0 T FD/0		Q □ DCA Othe	26. Place of Dea							
of	y Phy er this eral di	٦: <u>۲</u>	27. Manner of Death	28a. Date of Inju	ent 2 ER/O	Time of	28c. Injur	4 ⊔ Nursing H y at	28d. Describe h		Other (Speci	<i>fy)</i>			
ion	nding ath. r: Afte e fur	atio	1 Natural 5 Pending 2 Accident investig		y, Year)	Injury	Work	<br Yes 2 □No							
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within the June and the clearly for the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		ury - At home, for a contract of the contract	arm, stree	et, factory, office		28f. Location (S City or Tov	Street and vn, State)	d Number or Run	al Route Number,			
	To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination a	ge, death and/or inve	occurred at the tir estigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due t	stated. o the cause(s)			
	Within Congression	M	29b. Signature and title of certifier	middleton	w		29c. Licenso	e number		29d. Date	e signed (Month,	Day, Year)			
	10		30. Name and address of person	who completed cause of d		-	* 4	111	,	1	MI	21152			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	orke	Rd	VV.lst	m in Sy	21	1 110	21.7			
	Registr		NOV 3	0 2009 Len	ar's Signature	1. 1	harr								
511	MH 17 Rev 1/2	201		V LUVU /	- /	17									

Registrar

State

31. Date filed (Month, Day, Ye

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ 2009 November 1:10 A M Richard L. Bartholomew Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 1740 Ballenger Creek Pike Point of Rocks If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St (Month, Day, Year) 0ct. 25, 1966 New York 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 43 178-64-8485 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🖁 No Maryland Frederick Point of Rocks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1740 Ballenger Creek Pike 21777 United States 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Tool and Die Maker Machinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carla Kostka Jack Bartholomew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 je 1 and 2 s t of Health a If item 27 i <u> Loretta Bartholomew / Wife</u> 740 Ballenger Creek Pike, Point of Rocks, MD 21777 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 Important: If it any injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/2009 Frederick, Maryland Stauffer Crematory 21. Signature of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a considuence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Exam and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. 1 ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes 25 Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours a er death To the Funeral Director: After 1 Certificate: 1 Matural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled | by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier noleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore

412

Hetty Carraway

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orleans Street

32. Registra's Signature

000 57005

November 23, 2009

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Physician/ 2009 Harold E. Briggs 8:25 pM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Hillhaven Nursing Center Adelphi 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth Funeral May 27, 1920 1 ፟M 2 □ F Months Days Hours 009-05-3490 89 Yrs. Director Vermont Usual Residence of Decedent 28a-f shov 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 804 Gist Avenue 20910 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ WWII 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 A Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elvira Sayers ည Harry Briggs 19a. Informant's Name/Relationship (Type, Print) 2090 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 02 and 2 s Health a 3156 Gracefield Road, #222, Silver Spring, Francis Briggs/Brother item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) Dec. 3, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Signatur of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Dementia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Exam Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No cate has been signed by the a page 2 should be detached in g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Reactive Airway Disease 1 ☐ Yes 2^X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 🛣 No death? 1 ☐ Yes 2 ☐ No _ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 🙀 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending M ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, Division of Vital To the Hospital or Attending F within 24 hours after death.

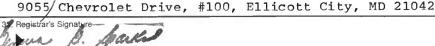
To the Funeral Director: After filled in by the completed 1041

Baltimore, Maryland 21215-0036

9055 Njideka Udochi, MD 31. Date filed (Month, Day, Year) State 02 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

December 1, 2009

29c. License number

D51897

3 Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland	l / Depa <i>Cer</i>	artment of F ctificate of	lealth and Death	Mental Hy	/giene	2009	40259
			Registrar  1. Decedent's Name (First, Middle, I	_ast)			imodic or i	Beatti	2. Date of D	eath		3. Time of Death
	Physici: /Medic		VICTORIA BERKUT	Α					12/01	_/200		12:30 A M
	Examin	er	4a. Facility Name (If not institution, g		hinat	on	4b. City, Town, or		ath		County of Death	
	Funeral	_	Hebrew Home of 6.  5. Social Security Number 6.	. Sex 7. Age	e (In yrs. las		Rockvill If Under 1 Year	If Under 24 Hr		irth	9. Birth	place (State or Foreign
	Director		138-10-5033	1□ M 2 <b>M</b> F 9	4	Yrs.	Months Days	Hours Mir	07/21/	1915	NJ	
	dand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	e Mary ta-f sh tiff, d	ctor	MD Montgom	ery	Beth	e <b>s</b> da						1 XYes 2 □ No
	vith the	Director	10e. Street and Number				10f. Zip Code				zen of What Cou	ntry?
	eath v	Funeral	6012 Grosvenor .	Lane 12. Was Decedent B	Ever in I.I.S.	13 \	20814	lienanic Origin?	Specify Ves or N	US	A 14. Race - Ameri	aan Indian
٥	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Exactivit must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2X1			Vas Decedent of H		rto Rican, etc.)		Black, White,	
1215-0036	ural",	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			l∐Yes 2 <b>X</b> No	Specify:			Specify: Whi	
-51	in 72 h	Completed	15. Decedent's (Specify only highest of	grade completed)		16a. Deced (Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wi d)	orking	16b. Ki	nd of Business/In	dustry
212	d with giene. er tha	Som	Elementary/Secondary (0-12)	College (1-4or 5		File (		,		Tria	angle Co	nduit Cable
and	be file	Be	17. Father's Name (First, Middle, La	st)					ame (First, Middle	•	Surname)	
ž	should nd Mei marke imatic	은	Joseph Petronis  19a. Informant's Name/Relationship	(Type Print)		19h Mailin	g Address (Street		na Mazur		r Town State 7ii	2 Code)
Σ Σ	alth ar 27 is er trau		Karen Balamaci				Grosvenor					, 0000
Baitimore, Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Modical Exercited must be notified an once.		20a. Method of Disposition  t√□ Burial 2 □ Cremation 3	☐ Removal from State 4	20b. Pla	ce of Disponentery, crem	sition (Name of natory or other plac	ee)	Date	20c. Lo	cation - City or To	own, State
Ē	t. Pag rtment rtant:		4 Donation 5 □Other (Spec	cify)	Day		emetery		04/09		ton, NJ	
g C	permi Depa Impo any Ir once	6	21. Signature of Funeral Service Lic	nsed Ku	end		Name and Address					0850
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death.							Approximate Interval Between
- Salar	Physician		Immediate Cause (Final disease or condition			tery (	disease					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a								
		Jer	Sequentially list conditions,	b. Due to (or see								
)	and and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Chroni			ilure					
5876U,	ificate be executed g physician and is the burial-transit	al Ex	resulting in death) Last	Due to (or as a	a conseque	nce of):						
		edical		d						=11		
X Q Q	The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	v		2	23d. Date of deliv	*
П	ne dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
7.	e law requires that the de has been signed by the le 2 should be detached		Part II. Other significant conditions	contributing to death bu	ut not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
Las	quires en sigr uld be	ed by	Dementia						. 10	Yes 2	X No 3 ☐ Proi	oably 4 Unknown
Hecords,	law re las bec 2 sho	Completed							24a. Was		24b. Were auto	ppsy findings available impletion of cause of
<u> </u>	: The cate h	Con							perf	ormed? 2 <b>X</b> No	death? 1 □ Yes	·
VII	siclan s certif irector	Be	25. Was case referred to medical - examiner? 1 ☐ Yes ② No	Hospital:		D/O. 4	Othe	ar.	eath (Check only			
0	ig Phy ter this neral d	ü	27. Manner of Death	28a. Date of Injur (Month, Day	v 2	8b. Time of Injury	t 3 DOA Othi	4 Nursing	Home 5 ☐ Res 28d. Describe		Other (Speci	fy)
VISION OF	tendin eath. or: Af the fur	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on	, reary	injury		Yes 2□No				
Ë	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hom :. (Specify)	e, farm, stre	et, factory, office			(Street and wn, State)	d Number or Rura )	al Route Number,
-	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page			Physician: To the best of								
	the Ho iin 24 i the Fu	Medical	(Check only 2 Medical Ex-	aminer: On the basis of and manner sta	examinatio ted.	on and/or inv	vestigation, in my o	pinion, death oc	curred at the time	, date and	place, and due t	o the cause(s)
	t 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2	29b. Signature and title of certifier	20/00	10		29c. Licens				e signed (Month,	
	4		30. Name and address of person wh			(3a) (Type 5	D0057			13	1,1500	``\
			Damien J. Doyle	1801 E. J	effer	son S	t, Rockvi	lle, MD	20852			
	Stat Registra	-	31. Date filed (Month, Day, Year)	38. Registra	r's Signater	bar	Kel					
			THE UNITED AND ALL	JUJ KURTINI	1	11						

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend item 23 pt. II per doc g898 I2-29-09 vt. State of Maryland / Department's: Headib and the mend item Certificate of Death

Reg. No. 2009 1 - For State Registrar 40260 2, Date of Death 1. Decedent's Name (First, Middle, Last) 11/29/2009 **Physician** 16:29 PHILIP JAMES BELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel Birthplace (State or Foreign Country)

MS 8. Date of Birth (Month, Day, Year) 07/13/1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours Months 81 Director 426-32-5729 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Exemplace must be not lifted at 1X Yes 2 □ No MD Laurel Prince George's Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 15603 Bradford Drive 20707 USA. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or increasing injury or other traumatic excess. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? ¹ □Yes 2 XNo Black, White, etc. 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify. à Specify: 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Company Chauffeur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Bell UKN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15603 Bradford Drive, Laurel, MD 20707 Ruth Y. Oliver - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 🗆 Removal from State vidence Mem Pk Cem 12/04/09 Metairie, LA 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Sign, we of Funeral Service 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fily one cause on each line. Immediate Cause (Final Acute renal failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyperkalemia Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran-Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Metabolic acidosis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Altered Mental Status 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Seisure disorder 24a. Was an page 2 s autopsy performed? 1 □Yes 2 ☑ No certificate Sepsis 1 ☐ Yes 2 ☐ No spital or Attending Physician; Theory after death, ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11/29/09 D41248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road, Laurel, MD 20707 George I. Okang, MD 31. Date filed (Month, Day, Year) 35. Registrar's Signat State **DFC** 02 Registrar

09-09588 Do

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

onald Billig		State of Maryland / Department of Health and Mental Hyglene  1-For State Certificate of Death Reg. No. 2 1 2 Pate of Death  1-For State Reg. No. 2 1 3 7 me of Death	26								
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  Donal Michael BILLIG  2. Date of Death  Month Day December 9, 2009  Year 1827 hrs									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 10945 Rocky Mount Way 4c. County of Death Montgomery									
Funeral Director	- 1	5. Social Security Number 119-24-6828  7. Age (In yrs. last birthday) 15. Under 1 Year If Under 24Hrs.  8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Find Properties) 129-24-6828  78  78  78  79  70  70  70  70  70  70  70  70  70	oreign								
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L 1 Yes 2									
with the Maryland ms 23a or 28a-f sho be notified at once	Dire	10945 Rocky Mount Way 20902 United States									
2 hours after death "natural", or iter Examiner must	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No No No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No No Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician  Medical									
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Sylvia Nydoff									
Z = 8 = 5	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
nore, MD 21 ages 1 and 2 should nt of Health and Me r: If item 27 is ma other traumatic ev		Bonnie Billig, Wife 10945 Rocky Mount Way, Silver Spring, MD 2090.  20a. Method of Disposition Date 20c. Location - City or Town, State									
Baltimore, In permit. Pages I and Department of Healt Important: If item injury or other trae		1 Name of the purish 2 Cremation 3 Removal from State Crematory or other place)  Mt Lebanon Cemetery 12/11/09 Adelphi. MD									
Saltir ermit. P bepartine mportai ajury or		21 Sun ture of Kineral Survice Licensee MOIOO'S TORCHINSKY Hebrew Funeral Home									
Physician Musical xaminer		254 Carroll St NW, Washington, DC 253. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Hydrocodone intoxication									
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60, ate be executed hysician and e burial - transit	dical	X UNPENDED 23a,27,28a-f,perM,e g898 12/21/09 TT									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ar								
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To the Hospi within 24 hou To the Funer completely fil	Medical C										
F % F 8	ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  December 10, 2009									
		30. Name and address of person who completed cause of reath (Item 23a)									
s	tate	31. Date filed (Month, Day, Year) 33. Registrar's Signature									
Regis		DEC 11 2009 Ceneur B. 4									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40262 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1007 Physician/ Month 7:54 AM 29 ROBERT L.T.NWOOD Medical CALLOWAY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Itospiec at Wicomico Salis Lury Lake If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 22, Birthplace (State or Foreign Country)
_ Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F Hours Director 1937<u>Pennsylvania</u> 214-34-7757 Usual Residence of Decedent 10h County 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f sho 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9908 Sharptown Road 21837 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be 1 traumatic Ruth Monica Doyle Frank L. Calloway Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Hume Court - Towson, Maryland 21204 <u> Mary Lee Whittington (Sister)</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/3/09 Mardela, Maryland Athol Baptist Cemetery Signature of Fundal Service Licensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Street - Crisfield, 306 W Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be as the l IF FEMALE: use Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) Month Dav Year detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò been signe should be Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 page 2 this certificate 1 Yes Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature.and title of certifier 29d. Date signed (Month, Day, Year) 11-29-2009

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

4330110

32. Regis

ar's Signature

GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR. SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 40263

			For State Registrar	State of Maryland / De <i>C</i>	ertificate of Death	Reg. No	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Mary E. Co	)X		2. Date of Death Month Dec. 9	3. Time of Death 11:30A м
	/Medic Examin	al	4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Deat	h 4c.	. County of Death
			108 Williams Str 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Bel Air  Bel Jean   If Under 24 Hrs.	9 Date of Birth	rford  9. Birthplace (State or Foreign
	Funeral Director		215-18-6623	7. Age (117) 13. 1031 bill 1102   88 Yrs	Months Davs Hours Min.	1 / 20/11 92 Year)	Maryland
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	he Mar 28a-fsl	Director	MD Harfor	d Bel		10g Ci	x Yes 2 □ No itizen of What Country?
	h with t		10e. Street and Number 108 Williams	Street	10f. Zip Code 21014	Tog. Of	USA
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If if health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the modified Examination and itself or other traumatic event, the modified Examination and itself or other traumatic event, the modified Examination and itself or other traumatic event, the modified Examination and itself or other traumatic event, the modified Examination and itself or other traumatic event, the modified Examination and the modified Examin	by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☒ Midowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes ② No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ▼	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
0-6121	within 72 hou ene. <b>than "natur</b> in verile	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (G	cedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired) memaker	rking	n home
מומו	ould be filed within Mental Hygiene. arked other than atic event, tre.	To Be Co	17. Father's Name (First, Middle, Last) Charles He	nry Bostick	18. Mother's Nar <b>Edith</b>	ne (First, Middle, Maider L. Norra	
, Mai y	and 2 shou alth and N 27 is mar er traumat		19a. Informant's Name/Relationship (Type R. Stephen Cox	- son   108	ailing Address (Street and Number or R Williams St., B	el Air,MD	21014
בי בי	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Report 4 □ Donation 5 □ Other (Specify)	poval from State 20b. Place of Dicemetery, of Bel Ai	sposition (Name of prematory or other place) r Mem. Gans 12/	Date 200. L	el Air, MD
1 0 1	permit. Departi Imports any inj		21. Signature of Puneral Service Lie see	disa	arkins F.H.Inc.	,600 Main	17314
1	Physician		23a. Part 1. Enter the disease or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition		enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death
d.	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	Hent Failure	102	
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions to the conditions of the conditio	Due to (or as a consequence of):			4(0)
5	execute n and ial-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	y harry,		y in
0/0/	cate be ohysicia the buri	edical	d.	hy	pertonian		y i m
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month D <i>a</i> y Ye <i>a</i> r
'n.	gned by	by Ph	Part II. Other significant conditions contri		e underlying cause given in Part I.		use contribute to the cause of death?
ecords,	require been si thould b	eted	Transition 1	schemic attack		1 Tes 2	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
vital net	in: The law ificate has or, page 2 s	- Completed	25. Was case referred to medical		26. Place of Do	24a. Was an autopsy performed?  1 □ Yes 2 ☑ N ath (Check only one)	prior to completion of cause of death?
>	hysicia nis cert I directe	To Be	l evaminer?	spital: 1 Inpatient 2 IER/Outpa	Other:	Home 5 Residence	6 ☐ Other (Specify)
	ding P h. After t funera	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tim Inju	e of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inju	ury occurred
DIVISION OF	al or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
	he Hospita in 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 Steptisting Physic (Check only one) 2 Medical Examine	cian: To the best of my knowledge, der: On the basis of examination and/der and manner stated.	eath occurred at the time, date and placer investigation, in my opinion, death occ	curred at the time, date ar	nd place, and due to the cause(s)
	To the To the Community of the Community	Z	29b. Signature and title of certifier	Mu un	29c. License number 0 2 7 97.	5 121	late signed (Month, Day, Year)
	1		30. Name and address of person who com	npleted cause of death (Item 23a) (Ty	pe, Print) 15 MOX PAAL	nd Bel.	Ang MR 21014
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Red		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 4:15 Α BETSY CATHERINE COSGRAVE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Date of bill. (Month, Day Yea 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🗓 F Days Hours Min. Marvland 214-80-1955 Director January Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Frederick Adamstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2190 Park Mills Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates ed other than "natural", event, the Medical Exar Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 rand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Practitioner Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic Perry C. Cosgrave Elaine Gouker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Det artment of Health ar Important: If item 27 is any injury or other trau once. Michael_Ennis / Husband 2190 Park Mills Road, Adamstown, Maryland 21710 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place) Mount Olivet Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Puneral Service Licensee Keeney and Basiord PA Funeral Home, MO1473 Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Influen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as t attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown as been signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? 2 No Yes 2 No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending work? 1 🗌 Yes 2 🗌 No injury Natural 5 Pending ☐ Accident ☐ Sulcide investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 04/2009 D69430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Street, Frederick, Maryland 21701 Nega Ali Goji. MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 17 2009 Registrar

**Physicia** /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 3

•	For State Registrar		State o	f Maryland		tificate					Reg. No.	/ 11	09	402	265
n il	1. Decedent's Name (if no 4a. Facility Name (if no		J.	nher)	CU	RTIS 4b City I	own, or	 Location o	D	2. Date of Dea Month	2 2	2 County	OS Death	3. Time of D	P ^M
r	The Johns H	, 0		iboly		Baltimore City					NONE				
	5. Social Security Nun 342–24–554	nber 6.	Sex 1 M 2 F	7. Age (In yrs. la 79	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	8, Date of Birt 8/1/8/1	1930		9. Birth	place (State or Tinois	Foreign
İ	Usual Residence of Do	ecedent Ob. County		10c. City	, Town or Lo	cation						_		10d. Inside City	/ Limits
5	Md.	Howard	1		rksvil							1 ☐ Yes 2 ☐XNo			
I Direc	10e. Street and Numb		nia Mill	Rd.		10f. Zip-Code 10 21029							Vhat Cour	ntry?	
by Funer	11. Marital Status  1 Never Married  3 Widowed 4		Armed Fo	² XNo		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒No Specify:  Specify: ₩							k, White,	etc.	
To Be Completed by Funeral Director	(Specify Elementary/Second	(Give life. L	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  Own Home								ndustry				
To Be C	17. Father's Name (Fin	C. Kel	ley	,				La	iura 7	(First, Middle	nare	11i			
	19a. Informant's Nam Thomas C.	•		đ	1	-				Route Numb	lark	svil	le,M	id. 2102	29
	20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery)  20c. Location - City or Town, State  12/7/2009  Clarksville,Md.  21. Signature of Funeral Service Licensee														
	21. Signature of Fune	ral Service Lic	ensee io-WHJ	MO1	044 4	2. Name and	d Addres	s of Facilit	Harry Dia P	y H.Wiike El	tzke lico	's F	amil City,	y F.H.] Md. 210	Inc. 043
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a lonsequence of):														
er	Sequentially list conditions,  b.  Due to or as a consequence of):														
cal Examine															
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12m 1 ☐ Yes 2 9 ☐ Unknown		1 Live	tcome of pregna birth 2 Tetal nant at time of de nown	death 3	Ectopic p		/					ite of deliventh		ear
d by Ph	Part II. Other signific	ant condition	s contributing to	death but not resi	ulting in the	underlying (	cause giv	ven in Part	l.	23e. Did 1				the cause of do	
omplete							***			24a. Was auto perfo 1  Yes				topsy findings a completion of ca 2 \( \square\) No	
Be	25. Was case referred examiner?	d to medical	Hospital	٠			Othe	or.		(Check only c					
1 Yes 2 No										e 5 Resi				ify)	
Medical Certification:	Accident  Suicide  Homicide	investiga 6 Could no determin	t be 28e. Place	me, farm, str	eet, factory		Yes 2 🗌		8f. Location City or Tox		(Street and Number or Rural Route Number, vn, State)				
dical Co	29a. Certifier 1 (check only 2 one)	Certifying  Medical E	Physician: To the xaminer: On the l	best of my know casis of examinat oner stated.	vledge, deatl ion and/or in	h occurred evestigation	at the tin	ne, date ar pinion, de	nd place, a ath occurre	and due to the	e cause (s	s) and m	anner as , and due	stated. e to the cause(s	)
Mec	29b. Signature and ti	tle of certifier	iller Pel		, M.I.	). R	License	number	X	}	29d. Da	ate signe	ed (Month	, Day, Year)	1)9
	30. Name and addres	ss of person w		use of death (Iten	n 23a) (Type,				600 N	lorth W	olfe S	St. Ba	altimo	ore. MD.	<del>- /</del> 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) DEC 0 4 2009

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Marylan			Mental Hygier	le Dun Cer	40266
			1 - State Registrar		Certifica	te of Death	Reg. N	10.	40200
ı	Physici	an	Decedent's Name (First, Middle, Last)		0 1		2. Date of Death Month D	Day Year	3. Time of Death
	/Media		Beturah .	Elizabeth	Cor		<u> </u>	25 2009	
	Examin	er	4a. Facility Name (If not institution, give st	The Park	4b. Cit	y, Town, or Location of Deat		tc. County of Death	
			5. Social Security Number 6. Sex	7. Age (In yrs. I	108 5	er 1 Year   If Under 24 Hrs.		Wicom	
*	Funeral Director			M 200 F	Yrs. Month:		(Month, Day, Yea	ir) Cou	nplace (State or Foreign untry)
			Usual Residence of Decedent				13/24/	919	1-10
	nylan thow	_	10a. State 10b. County		, Town or Location				10d. Inside City Limits
	Ba-fa	cto	MD Wicom	CO C	alisbu	79			1 PYes 2 □ No
	ith th	Director	10e. Street and Number	. 11 - 1 0	107	ip Code	10g. (	Citizen of What Cou	untry?
	a 23a		29339 Naylor 1	ull Rd A	,P+ e	21801		MS	·A
	item Item	Funeral	11. Marital Status 1 12 Never Married 2 Married 12	Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
336	lr, or	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ZÎNo If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	lack.
215-0036	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or terms 23a or 28a-f ahow event, tra Medical Enathinat must be notified at	ted	15. Decedent's Educa	ation	16a. Decedent's Us		16b.	Kind of Business/li	ndustry
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2	filed wil Hygien other th	Son	12-	,	Produc	tron Labor	er Co	ampbeli	Joup Co.
ם	be filed stal Hygie of other event, II	Be	17. Father's Name (First, Middle, Last)	- 1		18. Mother's Nar	me (First, Middle, Maide	en Sumame)	,
<u>ya</u>		9	Porter De	cal		RUB	y Das	hiell	
Maryland	2 a a		Informant's Name/Relationship (Type	e, Print)	19b. Mailing Addre	ss (Street and Number or Ru	iral Route Number, City	or Town, State, Zi	ip Code)
	s 1 and if Heelth Item 27 other tr		20a. Method of Disposition	U Depnew	lace of Disposition (N	14 201, XO	Date 20c	Location - City or 1	826
altimore,	8°= 5		Burial 2 Cremation 3 Re		emetery, crematory of	other place)	105/2	1/1	1 / C
틀	C 40 7		4 □Donation 5 □ Other (Specify)  21. Synature of Funeral Service Licensee	120		Memory ! //	98/2001	tebran	MD
B	Depart Depart Import any in		21. Milature Consideration Consideration	toch	22. Name	and Address Tacility	2000 14	417 1	W. Frabella
	_	_	23a. Part1. Enter the disease, or complication	ations that caused the death	Do not enter the m	ode of dving, such as cardiag	or respiratory arrest	1100 Sall	Shury MDZEO
*	Diametrica.		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	1 6		,		Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	stive 1	Heart Fail	cre		2405
н	Examiner			Due to (or as a consequ	/	4.			2-1-2
		Jer	Sequentially list conditions b. if any, leading to immediate	Due to (or as a consequ	c Steno	\$ (4			y
	outed od ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events						
o	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequ	uence of):				
8760	physici the bu	dicai	d.						
9		Med	IF FEMALE:			3.			
Box	death certifi e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna- 1 ☐ Live birth 2 ☐ Fetal		pregnancy		23d. Date of delin	very Day Year
o.	it the death certif by the attending tached for use as	Physician/Me	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5 Other (	specify)		Month	Day 19ai
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ĕ	The lay	Completed	Hyper Hensian	•			24a. Was an autopsy performed:	prior to c	topsy findings available completion of cause of
g	iclan: Th certificate rector, pag		Myeloid Dys  25. Was case referred to medical	flasia			1 □ Yes 2 🐼 I		210No
5	Attending Physiclan: The law or death. • cordificate has bector: After this certificate has by the funeral director, page 2 s	o Be	examiner?	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [	Othor	ath Check only one.  Home 5 MResidence	€ □Other (Con-	.4.)
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	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examine	cian: To the best of my known: On the basis of examinat	wledge, death occurre	d at the time, date and place	a, and due to the cause	(s) and manner as	stated. to the cause(s)
	hin 2. the I	Med	one)  29b. Signature and title of certifier	and manner stated.		9c. License number			
	2 3 5 2 2 3 5 2	-	200. Digitatoro and title of Certifier	line				Date signed (Month	
•	10			dim		D=4986	100	130/09	_
	84		30. Name and address of person who com	prieted cause of death (Item	1 23a) (Type, Print)	( D. P.	01.1	11 21	64
4	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture Dark	EN- 15/01	26(150019	17d 61	801
	Registr		UEC 0 1 20	Jy Lenner	1. 1				

09-09103 Gale Collins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 40267 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ Decedent's Name (First, Middle,Last) Month Day November 23, 2009 0155 hrs Medical Examiner Gale S. Collins 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Northwest Hospital 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Days Hours Months 1956comaryland Director 30 1 M 2X F 53 Sept. 220-70-1638 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location Yes 2 X No s 23a or 28a-f show e notified at once. 1aryland Baltimore Baltimore Director 10g, Citizen of What Country 10f. Zip Code 10e Street and Number 21208 501 Alter Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after death wit Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items' injury or other tranmatic event, the Medical Examiner must be. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes **Black** Yes 2 X No specify: Specify: 4 If Yes. Give Year 3 Widowed Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Bunrise Assisted Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th 0 Caregiver Living 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas E. Simmons Sr. Be Betty A. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, Carl Collins (Husband) Alter Ave. Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Crematory 11/25/09 Baltimore, Metro Donation 5 Other Specify: 22. Name and Address of Facility
Vm. Reese & Sons Mortuary,
B21 West St. Annapolis, Md 21. Signature of Funeral Service Licensee Tavy A. Beese novy 83 Approximate Interval 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Efter Underlying Couse Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit requires that the death certificate be executed Physician/Medical UNPENDED AMENDED e attending physician for use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 by the a Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ Yes 2 No 3 Probably 4 V Unknown Obesity Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? No Yes 2 ✓ Yes certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi npletely filled in by the funeral director, 25. Was case referred to medical Division of Vital æ examiner? Hospital: 1 Other₄ Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes ٩ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide within 24 hours at To the Funeral D determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 23, 2009 O.C.M.E. Grasse 4 30. Name and address of person who completed cause of death (item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month) Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**OCME** 

Physicia /Medic Examin

Funeral Director

	For	Pleas	State of M	laryland / D						9				
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	5. Social Security N	Social Security Number 6 Sex 7 Age (In vrs last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 F										te or Foreigr		
	217-58-2 Usual Residence of		1 X M 2 □ F	57	Yrs.	ontris Days	Hours Will.	Apr 11	, 19	, 1952 Maryland				
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ner	11. Marital Status		12. Was Decedent	t Ever in U.S.	13. Was	Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - A Black, W	merican Indian	,		
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0	LeRoy We	esly Cro	mwell				Emma Mae	e Dorsey	•					
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	20a. Method of Dis	•	_	20b. Place of cemeter	Disposition	n (Name of ry or other place	ee)	Date	20c. L	ocation - City	or Town, State			
		XCremation 3 5 ☐ Other (Spe	B □ Removal from State ecify)				matory 12	2/02/09	Wood	dbine,	MD			
	21. Signature of Fu	uneral Service L	censee //	1/04.054	GO11	me and Addre	ss of Facility Crematio	on Servi	.ce	P.O. I	30x 784	21020		
	23a, Part 1. Enter 1	the disease, or c	omplications that cause nly one cause on each	MO1251 ed the death. Do n	Beve not enter the	erly L. e mode of dvir	Heckrott	or respiratory a	CIa	arksvil	Approxim	nate		
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M	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcome							23d. Date of	delivery			
ciai	in the past 12	months?	4 ☐ Pregnant	2 ☐ Fetal death at time of death		opic pregnanc er <i>(specify)</i> _	у			Month	Day	Year		
nys	9 ☐ Unknown		9 ☐ Unknown											
Completed by Physician/Medic	Part II. Other signi	ficant condition	s contributing to death	but not resulting in	the underl	ying cause giv	en in Part I.				e to the cause			
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	1 X Natural 2 ☐ Accident	5 Pending investiga	(Month, D		njury N	Worl	ć? Yes 2 □No	Edd. Dodding (	1011 11110	ny coodinad				
E	3 Suicide	6 Could no	t be 28e. Place of In	njury - At home, far	rm, street, f			28f. Location (	Street a	nd Number or	Rural Route N	lumber,		
Seri	4 Homicide	3010111111	building, e	etc." (Specify)				City or To	vn, Stat	e)				
Medical Certification: 10	29a. Certifier (Check only one)		Physician: To the bes xaminer: On the basis and manner s	of examination and								se(s)		
Ме	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D											r)		
	<b>Q</b>		Tak .	no		72	14626		November 24, 2009					
	30. Name and add	ress of person w	ho completed cause of 501 W. 7th	death (Item 23a) (	Type, Print						•			
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r	OT, Date filed (IMO)	DEC 02	2009 32.Regist	J.	par	Les .								

DHMH 17 Rev 1/2001

State Registrar

241

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Daniel Bostic Campbell 29, 2009 November 7:12 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9501 Purcell Drive Potomac Montgomery 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 6. Sex 1**X** M 2□ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days July 9, South Carolina Director 249-14-5151 88 1921 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sh Examiner must be notified Director 1 ☐ Yes 2X No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9501 Purcell Drive 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Marketing Exec. Telecommunications .. Pages 1 and 2 should be filed v tment of Health and Mental Hygis tant: If item 27 Is marked other jury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William S. Campbell Quincey Mitchell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau Arlean C. Campbell/wife 9501 Purcell Drive Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 12/02/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Melanoma 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of trijury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ YNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🔀 No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45880 30 0

1521

State Registrar 32. Registrar's Signature

Leon Hwang, M.D. 1221 Mercantile Lane Largo, MD 20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parke

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State at 10a, 10b, 10c, 10e, 10f, 19b, 12-72-09 per FHDR, HCHD 10 at 10 green FHDR, HCHD 10 green FHDR, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ristenser Month lar November 26, 2009 /Medical 12:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elternhaus Assisted Living Howard Dayton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
_ **Funeral** Hours 1 ☐ M 2 🛣 F Director Yrs 204-09-8214 93 Pennsylvania 1916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 X No Howard Frederick Columbia Frederick MD 10e. Street and Number 10f. Zip Code 5316 Sovereign Place 10g. Citizen of What Country? 40962 Trott 21044 USA 21703 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 2 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hawley Clara Weatherbee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15316 Sovereign Place Wa Frederick, MD 21703-8381 19a. Informant's Name/Relationship (Type, Print) William C. Christensen/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or Final Journey Crematory 12/02/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UKKOOM Immediate Cause (Final disease or condition resulting in death) **Physician** tro /Medical Due to (or as a consequence, of Examiner Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 Yes € No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2500 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes this eral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 \( \text{Homicide} \) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies 29b. Signature and titte of gentifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSTIA CRNP SuitE Digital Dr 31. Date filed (Month, Day, Year)
DEC 0 2 2009 32. Registrar's Signature State acke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40271 1 - State
Registrar Amended#26perMD FCHD KS Certificate of Death 11/30/09 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER Day Year 23,2009 6:12A RALPH MELVIN CRONE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Days (M8nth 1^D2, /Tr 920 CouMD 220-30-9350 89 Yrs Director Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick MD 28a-f Middletown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3080 Lockwood Dr. 21769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White Completed 3 XWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) equipment operater county roads other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralph M. Crone Sr. Maude Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tran once. AnnFreysz (Step-Daughter) 3080 Lockwood Dr., Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cermetery, crematory or other place)
Clustered Spires Cem11/27/2009 Frederick, MD 1 ☑ Burya 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Condition 5 ☐ Cather (Specify) neval Ser 21. Sign 22. Name and Address of Facility
Donald B. Thompson Funeral Home
POB 18, Middletown, MD 21769 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. Immediate Cause (Final Onset and Death ARROST Physician/ CANDIAC disease or condition resulting in death) instant Medical Due to (or as a consequence of): Examiner CARDIO MY OPATHY Sequentially list conditions If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ ACRTIC STENUSII Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 4 hours after death.

*uneral Director: After the function of 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) D 22037 24/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brunswick MD 21716 ICin land 610 WINTH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

Box 68760

P.O.

**Division of Vital** 

32. Registrar's Signature

Brasiana

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBE! Dashevskiu Abram Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Russia 7. Age (In yrs. last birthday) 8 Date of Birth Funeral 1 🛛 M 2 🗆 F Hours Min 0 1 / 1 4 / 1 9 T 212-37-9608 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Rockville. 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11801 Rockville Pike, #401 20852 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Dentistru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boris Dashevskiu Rachel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khaya Dashevskaya - Wife 11801 Rockville Pike. #401. Rockville. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Judean Mem. Gardens 12/03/2009 Olney, Maryland 21. Signature of Funda Service Licens e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Day Year Pregnant at time of death 2 No the 9 I Inknown 9 Unknown P.O. ed by t signed by I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No Physician: The certificate 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) this in 24 hours after death.

the Funeral Director. After this
impleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Hospital or Attending Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one the 29b. Signature and trile of certific 29d. Date signed (Month, Day, Year)
PECEMBER 02, 2009 ٥ D 35436 HEROSEPP, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

DEC 03

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Phy 11/30/09 Carroll County, will State of Maryland / Department of Health and Mental Hygiene Amended Items 26 & 30 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Nov 26, Dwight Dingle 2009 11:30 a M /Medical 0. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 304 Cherry Chapel Rd. Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1**∑** M 2□ F Director 219-44-4012 63 Pennsylvania Nov 21, 1946 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland Baltimore 1 ☑ Yes 2 ☐ No Reisterstown Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? or items 23a or Funerail 304 Cherry Chapel Rd. 21136 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced "natural" White Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than" any Injury or other traumatic event, the Magnica. Elementary/Secondary (0-12) College (1-4or 5+) Station Manager WITR Radio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Betty Kendal Joseph H. Dingle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sue Dingle Wife 304 Cherry Chapel Rd. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 11/28/09 | Hampstead, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 15 disease or condition resulting in death) 2000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as attending p nse IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Ther (Specify) 1 | Yes 2 | HNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Beath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7123 11/27/0 20 30. Name and address with a how a Midnikove of differ 1750 of Marin Street, Reisterstown, MD 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 3 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Dorothy Elizabeth November Medical Dickerson 30 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03/21/1944 1 M 2 JXF Days Hours Min. 213-40-6488 Director 65 Yrs Avenue Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 10c. City Town or Location 10d. Inside City Limits MD St. Marv's 1 Q Yes 2 No Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 39410 Sunnyside Road 20624 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Specify: Black 3 🙀 Widowed 4 🗌 Divorced Year or Dates. other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11+h Building Service Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ bef Unknown if. Page 1 and 2 shours of Health and MF in mr 2 in mr Anna Louise Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. Pamela Pickeral/Daughter 39410 Sunnyside Road Clements MD. 20624 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sacred Heart ☐ Donation 5 ☐ Other (Specify) Cem. 12/4/09 Bushwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home hiteken 2294 Old Washington Road Waldorf MD. 20601 oduce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Hours Immediate Cause (Final Intoxcerebool Physician/ Hemmucrase disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Acute (RSPI getzry ta114/C DAYS Sequentially list conditions. frany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or, Em bolism pwmonso 0945 that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) months s Physician/Medical L445 cancel metastatic 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 1 Yes 2 9 Unknown signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe COPD cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Hegit Cunsestive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical was case roce examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 FR/Outpatient 3 DOA
Date of injury
(Month, Day, Year) 28b. Time of injury
28c. 27. Manner of Death
1 Natural
2 Accident Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours after Funeral Dire leted filled in b Medical within 24 hou

To the Funer

completed fil 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29c. License number

Registrar DHMH 17 Rev 7/2009

State

erson

68760

Records,

Division of Vital

St. Mary's Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 0 3 2009

59r

32. Registrar's Signature

Lusur

31. Date filed (Month, Day, Year)

00061719

Leonardtown

12-1-09

20650

	show		10a. State	10b. County		10c. Cit	ty, Town or	Locati	on						10d. Inside City Limits
	a-f st	tor	MD	Charle	s	La	Plata	ı							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Nur	mber					10f. Zip Co	de			10g. (	Citizen of What C	ountry?
	3a or		9425 Silv	ver Oak R	d.					064	6			USA	
36	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or liems 23a or 28a-f show event, the Medical Examinar must be notified at	y Funeral		ied 2 Married	12. Was Decedent I Armed Forces? 1♣¥es 2 ☐ N If Yes, Give	10			Decedent es, specify (	_	panic Origin? , Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Am Black, Whi Specify. Whi	te etc
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Mar	alth a		19a. Informant's Na Doreen De	ame/Relationship ( empsey/Wi	Type. Print) fe			-				Rural Route Num aPlata,	-	y or Town, State, 20646	Zip Code)
	permit. Pages 1 a Department of He Important: If Item any Injury or othe				Removal from State	20b. f	Place of Dis	spositio	on (Name o	of nlace	)	Date	20c.	Location - City or	Town, State
alti	mit. F partm sortal / Inju		21. Signature of Fu		,,		T	æRN	PHENERAPA	dones:	HOTa <b>S</b> ityFII	NERAL HO	)ME.	PA	
ñ	Depa Impo any Ir		X/A	1/ N	Flent	MO	0945							Md. 206	546
	2000		23a. Part 1. Enter the	he disease, or com	plications that caused one cause on each lin	the deat									Approximate Interval Between
-	Physician		Immediate Cause (	Final	_a End St		Livei	- Di	sease	2					Onset and Death
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	Examiner		Sequentially list con												
	cuted Id ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a conseq	uence of):								
,092	death certificate be executed e attending physician and d for use as the burial-transit		resulting in death) L	ast	Due to (or as	a conseq	uence of):								
89	ifficat g phy as the	edic			- u.										
O. Box 68760,	te death certificate be executed the attending physician and ned for use as the burial-transit	Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Ves   2   No   9   Unknown   23d. Date of deliver from the past 12 months?   1   Ves   2   No   9   Unknown   10   Ves   2   No   No   No   No   No   No   No										elivery Day Year		
σ.	that the de ned by the a detached t	Ph		icant conditions of	ontributing to death bu	ut not res	ulting in the	e unde	rlying cause	e giver	n in Part I.	23e. Dio	tobacc	o use contribute t	to the cause of death?
tal Records,	aw requires that s been signed b s should be deta	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Protection   Part II.										Probably 4X Unknown		
Reco	e e	mple					-					24a. Wa aut per	s an opsy formed?	prior to	
ta	lan: The rtificate h tor, page	ပိ	25. Was case referr	red to medical							26 Place of D	1 ☐ Yes eath (Check only		No 1 □Ye	s 2x No
	/sicla	To B	examiner? 1 ☐ Yes 2 🛣		Hospital:	nt 2 🗆	FB/Outna	tient	3 🗆 DOA	Other				6 ☐ Other (Sp	ooifu)
Division of V	ding Phy h. After thi funeral o	tion: T	27. Manner of Death		28a. Date of Injui (Month, Day	ry	28b. Time Injur	e of y	28c.	Injury Work?		28d. Describe			ecnyj
ivisi	or Attendi ifter death. Director: A in by the fu	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ry - At ho	ome, farm, y)					28f. Location City or To	(Street own, Sta	and Number or F ate)	Rural Route Number,
	To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this cer completely filled in by the funeral direct		29a. Certifier (Check only	1 Certifying Ph 2 Medical Exam	nysician: To the best on the basis of	of my kno	wledge, de	eath oc	curred at th	he time	e, date and pla	ce, and due to th	ne cause	e(s) and manner a	as stated.
	the thin 2 the function 2 the functi	Medical	one) 29b. Signature and		and manner sta	ted.			29c. Lic						
	<b>₽</b> ₹ <b>₽</b> 8	-	29b. Signature and	Zah	nD.				0		5606	2	290. 1	Date signed (Mon	19
A 1	8(2)		30. Name and address	ess of person who aljit Nag	completed cause of de	eath (Iten	n 23a) (Typ	e, Prin Lan	Rd. S	Sil	ver Spr	ing, Md	. 20	910-1484	/ ₊
	Sta Registr	te ar	31. Date filed (Mont	DEC 0 3	2009 32. Registra	ır's Signa	ture A.	b	wed	,					
DHN	/IH 17 Rev 1/2	001			- //		-	- /							
							OR	IGIN	AL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Min.

Silver Spring

Days

2. Date of Death

November 28, 2009

8. Date of Birth Jan. 15, 1931

4c. County of Death

Montgomery

9:00 p M

9. Birthplace (State or Foreign Country) PA

10d. Inside City Limits

1 - For State Registrar

Richard

5. Social Security Number

069-24-7162

Usual Residence of Decedent

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

Holy Cross Hospital

Earl Dempsey

6. Sex 1 ★ M 2 □ F

7. Age (In yrs. last birthday)

78

4a. Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40276 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 12:20 A M Janet H. DeLaRosa November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 525 Sylvan Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 22, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min 213-94-4203 1 🗆 M 2 🛛 F Months Days Hours Mary land 1975 Director Sept. 34 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Frederick Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 21703 United States 525 Sylvan Court 23a death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify "natural", 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) should be filed within and Mental Hygiene. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luis R. Valladarus Marta Calderon other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>. 20</u> 1 and 2 s of Health item 27 Yonal DeLaRosa / Husband 525 Sylvan Court, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 12/1/2009 Stauffer Crematory 21. Signature of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate
Enter Industrying
Cause (Disease or iinjury Due to (or as a consequence of) Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Medical Box 68760 IE FEMALE Physician/ 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2X No 3 Probably 4 Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 V No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 🔯 Residence 6 🗆 Other (Specify) 1 \( \text{Yes} 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 🔀 Natural 5 Pending 1 Yes 2 No the f Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

10

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Chitra Rajalopal MD, 18111 Prince Philip Dr., Olney, MD 20832

29c. License numbe

D#2452

29d. Date signed (Month, Day, Year)

November 30, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 5:30A NOV 25 JOHN MARION DRESCHER, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CLARKSBURG FREDERICK 2224 REGINA DRIVE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 22 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** 1923 Days Months 1 M 2□ F 85 WASH 579-40-7807 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov ed other than "natural", or items 23a or 28a-f show event, the Modical Evanings must be notified at 1 ☐ Yes 2 No Director CLARKSBURG MD FREDERICK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20871 2224 REGINA DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1 9 4 3 If Yes, Give 1 9 4 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 WHITE Year or Dates: 1945 Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 I n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT PROCUREMENT OFFICER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic eventone. Be JOHN MARION DRESCHER, SR. NELLIE HARVEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2224 REGINA DR., CLARKSBURG, MD 20871 CHRISTINE DRESCHER/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. MARY S CHURCH 11/28/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BARNESVILLE, 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Vicensee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 Approximate Interval Between Onset and Death 23a. l'art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CHNCER LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the local policy cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

24 hours after death. Funeral Director: A filled in by within 24 hou To the Fune completely fi

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State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of cortifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 9707 MEDICAL CENTER DR., ROCKVILLE, MD 20850 THAMBI,

31. Date filed (Month, Day, Year)

32. Registra s Signature 2009 ▶

and manner stated.

Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOD 61083

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 12:25 aM November Aneta Ene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
Oct. 25, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral 1 M 2 A Months 213-13-3861 97 Director 1912 Romania Usual Residence of Decedent Show 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a Funeral 8918 Centerway Road 20879 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 ☐ Yo "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give SpecifyWhite 3 ₺ Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Financial Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Management 10 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vartan Vartanof Maria Emilia Stazetzky 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane E. Crisen/Daughter 8918 Centerway Road, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dec. 2009 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Lige ew MD 20901 23a. Part 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial Hemorrhage, non-traumatic unknown disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Pregnant at time of death 9 Unknown 1 Yes 2 9 Unknown the signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? certificate ! Yes 2 X No 1 Yes 2 No Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 2 **X**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ▼ Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation within 24 hours after death

To the Funeral Director; completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 돈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only o з 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signatur 3 D65720 November 30, 2009 seman e and address of person who a cause of death (Item 23a

State

Registrar

ark

💪Georgetown Road, Bethesda, MD 20814

8600 01/d

MD

Rosemary Iwunze,

Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 Edwin J. Edwards 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SALISBUM HICOMICO REGIONAL TENINSUM If Under 1 Year | If Under 2/ 8. Date of Birth (Month, Day, Year) May 1, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday Days 1 X M 2 □ F Maryland 78 May 213-28-6166 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Frankford Sussex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19945 U.S.A. 33117 Omar Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 11. Marital Status 1 ☐ Never Married 2 X Married 1 **∑**Yes 2 □ No If Yes, Give Ye*a*r or Dates: **"50-"54** 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Emory Paul Edwards** Stella Faye (Reeves) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edwin J. Edwards, Jr., / Son 38391 Bluebird Lane, #392, Selbyville, DE 19975 20b. Place of Disposition (Name of cametery, crematory or other place) Eastern Shore 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/01/2009 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 22. Name and Address of Facility Parsell Funeral Enterprises, Inc. 34874 Atlantic Ave., Ocean View, DE 19970 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenia disease or condition resulting in death) Due to (or as a consequate of): Congestive Sequentially list conditions Due to (or as a co sequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cormany 0/4 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 □ No Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

and

Department of Important: If it any injury or o once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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DE

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a.f show

Pages 1 and 2 sl ment of Health an

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Eventuals is mutilied at

Examiner burial-tran

Physician/Medical 2

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

the attending physician ned for use as the burial

The law requires that the death certificate be executed is been signed by the should be detached certificate has page 2 or Attending Physician: funeral director, After this the filled in by

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: Hospital

completely

Registrar

Medical

Be Completed 25. Was case referred to medical examiner' Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SRLIBURY

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

D41721

29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAVLOS 400 E, SHORE DR MD

32. Registrar's Signature, Year) 31. Date filed (Month 0

			For State Registrar		State of M	larylan		rtment of tificate of			vientai H	ygie Reg.	No. 20	09	40280				
	Physicia	an	1. Decedent's Name	e (First, Middle, Last) M		ishma	n				2. Date of D Month Novemb	eath er	30, 20	009°	3. Time of Death 9:42 PM				
	/Medic Examin			f not institution, give			-	4b. City, Town,	or Locatio	n of Deatl	.1		4c. County		7.12 111				
and the second				an Hospita				Bethe					Mont						
	Funeral Director		5. Social Security N 109-09-59	961 1	7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of E	3, Birth Day, Ye	1913	9. Birthp Cour New	place (State or Foreign htry) York				
	sryland show	7	Usual Residence of 10a. State	10b. County			y, Town or Lo							1	0d. Inside City Limits 1 ☑ Yes 2 ☑ No				
	he Ma 28a-f	Director	MD 10e. Street and Nu	Montgomer	У	Ch	evy Ch	ase 10f. Zip Code				10a	. Citizen of \	What Cour					
	with t	Ē		consin Ave	nue #16	21		2081					USA	Wild Ood					
0	should be filed within 72 hours after death with the Maryland and Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the "section Evention rough to neithed minatic event, the "section to remain the neithed minatic event," the "section to remain the neithed minatic event, and the neithed minatic event event.	Funeral	11. Marital Status		12. Was Deceder Armed Forces 1XYes 2	t Ever in U.		Was Decedent of f Yes, specify Cu			pecify Yes or f o Rican, etc.)	No-	Bla	ck, White,	can Indian, etc.				
<u></u>	ral",o	d by	3 🛛 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates	[:] 1942-	-1944	1∐Yes 2∭XNo	Speci	ty:			Specif	WIII					
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12.	within iene. <b>than</b>	duc	Elementary/Seco	ondary (0-12)	College (1-4o	r 5+)	Cler		<i>eu)</i>				Feder Admin						
2	other	Be C	17. Father's Name	(First, Middle, Last)		-	L,		18. Mo	ther's Nar	ne (First, Mida	lle, Mai	iden Surnan	ne)					
<u>/lar</u>	should be and Mental a marked of umatic ev	T0 E	Sam Fish	man					Je	nnie	Shavin								
lar.	2 sho n and is ma			ame/Relationship (Ty				ng Address (Stree					-						
e,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		Jerrold 20a. Method of Dis	Fishman/ N	<u>ephew</u>	20b F		E. 78th sition (Name of natory or other pi		et, I	New Yor		c. Location						
ğ	ages ent of tt: If it y or o		1 Burial 2	☐ Cremation 3 🔯 5 ☐ Other (Specify)	Removal from Stat	e i		natory`or other pi .d Cemete		12-4	4-09	Ho	11ywo	od. E	rT.				
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.			peral Service Licens	ee UO	1008			ress of Fac	cility To	orchins	kу	Hebre	w Fur	eral Home				
m —	De d					5				254 (	Carroll	St	NW W	ashir	igton, DC				
	Physician /Medical		23a. Part 1. Sinted a shock, or lead immediate Cause disease or condition resulting in death)	on .	ne cause on each	erosc	leroti	er the mode of d			c or respiratory	arrest	t,		Approximate Interval Between Onset and Death				
	Examiner		Sequentially list co	nditions.	o														
	ted nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying injury	Due to (or a	is a conseq	uence of):												
<u></u>	ificate be executed g physician and as the burial-transit	Exar	that initiated events resulting in death)	S 🔳 (	Due to (or a	as a conseq	uence of):					_							
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89		Med	IF FEMALE:						- 17					-					
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months? □ No	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknowr	n 2□Feta tat time of d	I death 3	☐ Ectopic pregna ☐ Other (specify)				-		ate of deliv	rery Day Year				
ds, P.	w requires that the di been signed by the should be detached	b	Part II. Other signi	ficant conditions co	ntributing to death	but not res	ulting in the u	nderlying cause (	given in Pa	rt I.			cco use con 2 ⊠No		the cause of death?				
Secol	e faw req has beer ge 2 shou	Completed									24a. W	topsv		Were auto prior to co death?	opsy findings available ompletion of cause of				
æ	in: Th		25. Was case refe	rred to medical					26 PI	ace of De	1 □ Ye: ath (Check onl		Дійо	1 □Yes	2 □ No				
>	ysicla is cer direct	o Be	examiner? 1∐Yes 2√2	<u> </u>	Hospital:	atient 2 🗆	ER/Outpatie	nt 3 DOA	thor-		Home 5 ☐ R		ce 6 □Ot	her (Spec	ify)				
Division of Vital Records,	nding Physician: The lath. r: After this certificate he funeral director, page	ation: T	27. Manner of Dea 1 Natural 2 Accident	th 5 Pending investigation	28a. Date of li (Month, I	njury Day, Year)	28b. Time o Injury	W	jury at ork? □Yes 2	□No	28d. Describ	e how	injury occu	rred					
Divis	pital or Attenours after deatleral Director:	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of building,	Injury - At he etc. <i>(Sp</i> ec <i>i</i>	ome, farm, str	reet, factory, offic	е		28f. Location City or	n (Stre Town, S	et and Num State)	ber or Rur	al Route Number,				
	To the Hospit within 24 hour To the Funers completely fills	Medical (	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	sician: To the be iner: On the basis and manner	of examina	owledge, deat ation and/or in	th occurred at the evestigation, in m	time, date y opinion,	and placed	e, and due to surred at the tin	the cau	use(s) and n e and place	nanner as , and due	stated. to the cause(s)				
	Vithir To th	Me	29b. Signature and	title of certifier				1	nse numb			290	d. Date sign	ed (Month	, Day, Year)				
	10+1		<b>)</b>	1 Lel	5			DO	254	80		H	130/3	1000					
				ress of person who co	dy, MD	860	0 01d	Georgeto	wn Ro	d., B	ethesd	a, 1	MD 208	314					
	Sta Registi		31. Date filed (Mor		32. degi	strar's Signe	A. A	arked											

NOV 30, 2009 9:42 PM

FISHMAN, GERSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 40281 Registrar AMEND#20b, coerFH, 12/8/09, BW. McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret C. Fisher Physician/ December 1, Day 2009 Year 9:10 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 1923 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 578-22-3417 1 □ M 2 1 F Months Days Hours Min. 86 North Carolina Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13105 Grenoble Drive 20853 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ğ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: White Completed 3 x Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) National Institutes of Medical Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Merton T. Cutler Ethel Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Betty J. Barber/Daughter 3630 Woodbine Road, Woodbine, MD 21797 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ROCKVILLE, Maryland December 7 cemetery, crematory or other place)
te of Heaven Cemetery
rk Lawn Mem. Park 1 Burial 2 Cremation 3 Removal from State 2009 4 Donation 5 Other (Specify) Silver Spring, Maryland Parklawn Mem. Signatu f Funeral Service Licens ²² Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Dun to (or as a nonesquence of) frank leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 nding t se as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year signed by the at d be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Artery Disease, Lumbar Spinal Stenosis, Division of Vital Records, 1 Tes 2 No 3 Probably 4 18 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 2 🗷 No 25. Was case referred to medical the funeral director, B B 26. Place of Death (Check only one) examiner?
1 \( \subseteq \text{Yes} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 😾 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred **XX** Natural (Month, Day, Year) 5 Pending work s after death Director: A Accident 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

pleted filled in by ithin 24 hours a Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) December 2, 2009 D52503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shailesh Sheth, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) . Registrar's Gignat State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death REELS Physician/ DI M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 Director 213-27-4722 30 1/8/1979 Usual Residence of Decedent 23a or 28a-f shov and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George Bowie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17408 Central Ave. 20716 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Opticians Asst. Optometry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John Reil Catherine Kidwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Freels item 27 Spouse 17408 Central Ave. Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 12/8/2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee any in 22. Name and Address of Facility Hardesty Funeral Home, P.A. 17 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and De Physician/ W 1064 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 2 [ 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) ho completed

State Registrar Date filed (Month, Day, Year)

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 U U 9

State Registrar 29a. Certifier

29b. Signature and title of certifier

Medical

Robin Bissell, 124 Miller St., Grantsville, MD 21536 32. Registrar's Signature

31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

December 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death T. Month **Physician** MARIE GROGAN 15:38pm 2009 05 *YMedical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Laurel Regional Hospital Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 23,1933 9. Birthplace (State or Foreign last birthday) Funeral Months Days Hours 1 □ M 2 F 408-48-6857 76 Tennessee **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, It Modical Exemitment Les notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Beltsville 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20705 United States 4409 Greenwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 □Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Goddard Space Flight Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Oliver Frederick L. Thomas ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4409 Greenwood Road Beltsville, Maryland 20705 Regis Allen Grogan -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 12/8/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tracranial Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ■ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rellitus 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled filled l 🖷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examination on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0063 5 001

Registrar
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lacoub

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ruth E Grogg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-RMC Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Ye Mar 20, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. 1 □ M 2 □ 5 507-24-3040 NE **Director** 83 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Allegany MD Cumberland 1 □¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Humbird Street 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinations once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2□No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo If Yes. Give ģ 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bartender Sportsman Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius H. Brown Victoria Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Foreman daughter 232 Mary Street Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/14/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Parent Home, PA 21. Sign of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) as been signed by the 2 should be detached 1 □Yes 2 □ No. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha 2-110 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 100 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir After this 27. Manus of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide n 24 hours a Medical 29a. Certifier 🗠 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnet stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

KHANNA

DEC 17 2009

DHMH 17 Rev 1/2001

HIGHWAY CUMPER AND MOSER

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henry C. Granger December 2009 1:30 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Care & Rehabilitation Center Frederick Frederick Social Security Number 025-14-2504 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Massachusetts 1 😿 M 2 🗆 F Hours Min. 93 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Ħ 10a. State Director Frederick Maryland Frederick be notified 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must be 1900 Rosemont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 🕱 Yes 2 🗆 No 1942 - If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Delivery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver ပ Granger Mary Silas 19a, Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Persimmon Drive, Ijamsville, Maryland 21754 Mr. Leonard Granger, Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Smithsburg Crematory Dec 14, 2009 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funerall Service License ²²Kleeney and Basford PA Funeral Home cel 106 East Church St., Frederick, MD 21701 23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in modiate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death g Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b d be deta 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown or Attending Physician: The law requires 1 🗌 Yes icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to comp death? autopsy perform certificate No 1 Tyes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Hospital Other: 2 1 Tyes Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or invest Certifying Nurse Practioner: To the best of my knowledge, (Check death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I only one) 29b. Signature ar December 14, 2009 de man use of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

2

State

30. Name and address of person who completed c

2009

17

Kaufmann

M.D.,

32, Registrar's Signature

Robert L.

31. Date filed (Month, Day, Year)

300 West Ninth Street,

Frederick, Maryland 21701

Registrar

State

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

Ammended Box 4C & 26 Per Phys. WSH Carroll Co. 12/2/09 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Year 09 Evelyn Glaser 27 9:00mm 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore County 4b. City, Town, or Location of Death 3542 Hernwood RD 21163 Woodstock, MD 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 1 □ M 2 □ F 220-05-9186 89 1920 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Woodstock 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3542 Hernwood Road 21163 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic

3	rs af	g	3 XWidowed 4 Divorced	Year or Dates.		1 L Yes	2 X No Sp	ecity:		Specify: Wh	ıte	
2-00-	"natu dical	plet	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usu	al Occupation	most of working		16b. Kind of Business	Industry	
V	within 72 hours af giene. er than "natural" , the Medical Exa	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		(Give kind of wo life. DO NOT use	•	most of working		domestic		
7	d wit Hygie ther nt, th	Be C	17. Father's Name (First, Middle, Last)		nc	memaker		A death and a Alaman (F		4-1-1		
/land	2 should be filed within 72 hours af th and Mental Hyglene. Z7 is marked other than "natural" traumatic event, the Medical Exe	10E	Harry Marley					Mother's Name <i>(F</i> <b>1iriam Z</b> :				
Mar	d 2 should alth and M 1 27 is mar er traumat		19a. Informant's Name/Relationship (7) Barbara Stiegler			•				City or Town, State, Zi	ip Code)	
pallimore,	Page 1 and nent of Heal ant: If item 3 iry or other		20a. Method of Disposition 1	Removal from State	cemeter	Disposition (Nar y, crematory or c S Churc	ther place)	Date 12-1-0	1	20c. Location - City or		
Dall	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens Page Saign		•			Sykesvi		eral Home 8 D 21784	& Chapel	
1	nysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the ne cause on each line.	death. Do n	ot enter the mod	le of dying, suc	ch as cardiac or re	spiratory arre	st,	Approximate Interval Between Onset and Death	
	Medical Examiner	r.	resulting in death)  Sequentially list conditions,	b. Card	nsequence o	- 1)4	srh	ythm	ia		2 wks	
	cuted nd ransit	kamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events	Due to (or as a co	·		<u> </u>					
3	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a co	nsequence o	of):						
DO / 00 YOU	e death certifice the attending p hed for use as t	Completed by Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1  Live Birth 2 4  Pregnant at tim 9  Unknown	regnancy Fetal death ne of death	3	pregnancy pecify)			23d. Date of de Month	olivery Day Year	
	uires that the signed by all be detact	ed by Ph	Part II. Other significant conditions of				cause given in	Part I.		pacco use contribute to	o the cause of death?	
secords,	The law req ate has bee bage 2 sho	complet							24a. Was ar autops perforr 1 \(\sum \) Yes	y prior to death?	utopsy findings available completion of cause of	
ō	sian: ertifica ctor, p	Be (	25. Was case referred to medical examiner?					Death (Check on		<i>(</i> )		
5	hysic his of	유	1 🗆 Yes 2 No	Hospital: 1 Inpatient		tpatient 3 D		☐ Nursing Home	5 Reside	nce 6 Other (Spec	cify)	
	ending P sath. vr: After t he funera	Certificate:	27. Manner of Death  Natural 5 Pending Accident Investigation		ear) 28b. T	ime of njury M	28c. Injury at work? 1 ☐ Yes		. Describe ho	w injury occurred		
DIVISION	al or Atto s after de al Directo ed in by th		3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, far pecify)	m, street, factor	y, office	28f	. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,	
	he Hospit in 24 hour he Funerz pleted fille	Medical	29a. Certifier (Check only one)  1									
_	Vith Total	-	29b. Signature and title of certifier	1		290	c. License num	ber	2	9d. Date signed (Monta	h, Day, Year)	
			" (inthesida	relemo			D20	835		11/30/20	009	
بار	143		30. Name and address of person who	completed cause of death		Type, Print)	ich Re	1540 20	o Bat	timene Me	on-lend 2122/	

State

Registrar

31. Date filed (Month, Day, Year)

Physician/

Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

ō

Director

Funeral

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death with the Maryland

parked

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Marylar			of Heale of Dea			ene 9. No. 2	119	40290
	Physicia	เท	1. Decedent's Name (First, Middle, Last) ANNETTA M. GC	DHARD	_			1	2. Date of Death Month November	Day 24 2	Year 009	3. Time of Death 8:44 A ^M
	/Medic Examin	-	a. Facility Name (If not institution, give state) Casey House/Montgo		2		Town, or Loca	ation of Death		4c. County Mon	of Death	ery
	Funeral Director		5. Social Security Number 6. Sex	M 2 <b>⊠</b> F 7. Age (In yrs. 84		If Under Months	1 Year   If L	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Oct. 1	Year)	9. Birthp Coun	lace (State or Foreign
	Maryland a-f show	.	Usual Residence of Decedent  10a. State 10b. County  Md. Montgome		ty, Town or Lo	cation cville	<u> </u>				1	0d. Inside City Limits 1X Yes 2 □ No
	with the a or 28: be not	▭	10e. Street and Number 14401 Traville Gat	rden Circle	#112	10f. Zip	Code 20850	<u> </u>	10	g. Citizen of V Unite		•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Italy Arcal Even incompation of the partition once.	by Fur		2. Was Decedent Ever in U Armed Forces? 1 _Yes 2 No If Yes, Give Year or Dates:	.S. 13.	Was Deced If Yes, spec 1 □Yes	ent of Hispar ify Cuban, M		ecify Yes or No- Rican, etc.)	14. Rac Blac	e - Americ ck, White, e	an Indian, etc.
21215-0036	within 72 hou iene. • than "nature !	Be Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed)  College (1-4or 5+)	(Give life. I		e retired)	g most of worki		6b. Kind of Bi		
nd 2	be filed tal Hyg d other event, I		17. Father's Name (First, Middle, Last)	-Dhaman				Mother's Name Annetta	(First, Middle, M	aiden Surnan 11iams	ne)	
Maryla	12 should the nand Men of is marked traumatic	ပ	Raymond James Mo  19a. Informant's Name/Relationship (Typ  Janet M. Schoengo			ng Address 25 Gr:	(Street and I	Number or Rura	al Route Number,	City or Town,	, State, Zip Md •	Code) 20855
Baltimore, Maryland	Pages 1 and ent of Healt nt: If item 2 ry or other		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b.	Place of Dispo cemetery, crer tropoli			11/2		Oc. Location	-	
Baltii	permit. B Departm Importar any inju	I	21. Signature of Funeral Service licens	5038,	Funeral Laytonsv	ille,	Md. 2					
	rificate be executed  'g physician and as the burial-transit  as the burial-transit	al Examiner	23a. Par/1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line.  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate interval Between Onset and Death
O. Box 687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2 Fe	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						ate of deliv	rery Day Year
rds, P.	puires that in signed by all be detailed	ক্র	Part II. Other significant conditions con Diabetes Mellitu		sulting in the u	underlying o	ause given ir	Part I.				the cause of death?
of Vital Records,	: The law requir cate has been si , page 2 should I	Completed	Coronary Artery	Disease					24a. Was ar autops perforn 1 □ Yes 2	y ned? ☑ ☑ No	Were auto prior to co death? 1 \( \subseteq Yes	opsy findings available ompletion of cause of
Vita	Physician: The I rthis certificate hi ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie	ent 3 □ D			h <i>(Check only on</i> ome 5 ☐ Reside		ther (Speci	ify) Hospice
ion of	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral to	Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes		28d. Describe ho	w injury occu	rred	
Division	ral or Atters after de al Directo	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	y, office		City or Towi	n, State)		ral Route Number,			
	e Hosp 124 hou e Funei letely fil	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	at the time, n, in my opini	date and place on, death occu	, and due to the d rred at the time, d	ause(s) and r ate and place	, and due	to the cause(s)			
	To the within To the Complete	29b. Signature and title of certifier  29c. License number  D 63 748  29d. Date signed (Month, Day, November 24,										
	8		30. Name and address of person who co		em 23a) (Type	, Print) caste	r Mill	Road,	Rockvil	Le, Md.	. 20	855
	Sta	Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road, Rockville, Md. 20855  State  31. Date filed (Month, Day, Year) 30 2009 State  32. Registrar's Signature										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 23, 2009 **Physician** 7:15P. A. **EMORY** HARMAN, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Necitas Assisted Living Home 8. Date of Birth Feb. 28, 1917 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours Marviand 1**X** M 2□ F 92 219-07-5822 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evantiner must be notified at 1 ☐ Yes 2 XNo Silver Spring Montgomery Marvland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 13833 Overton Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Government Postmaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Hedrick Frederick August Harman မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 122 Duvall Lane, #304 Gaithersburg, Maryland 20877 Emory A. Harman, Jr. -son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenbelt City Cemetery 12/2/2009 Greenbelt, Maryland Bornald Wores Borgwardt Funeral Home, PA 21. Signature of For Service Licensee 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebralvascular Disease days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia; CHF; Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 1 ☐ Yes 2X No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other:  $_{4\,\square\,\,\text{Nursing Home}}$  5  $_{\square}\,\,$  Residence 6  $\underline{\hspace{-0.1cm}\text{M}}$  Other  $\underline{\hspace{-0.1cm}\text{Ags}}$   $\underline{\hspace{-0.1cm}\text{is ted}}$   $\underline{\hspace{-0.1cm}\text{Lvg}}$  . Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 10

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person where Peter Stengel,

31. Date filed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print)
M.D. 7525 Greenway Center Drive, T4 Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

			For State Of IVI State Registrar	aryland / Depa	rtificate of L	Death	Reg.	2009	40292
	sicia		1. Decedent's Name (First, Middle, Last)  Blanche Lee Hargis				2. Date of Death Month ecember 1	Pgy, 2009	3. Time of Death 9:54 PM M
	ledic amin		4a. Facility Name (if not institution, give street and number)  Homewood at Crumland Farms		4b. City, Town, or	r Location of Death		4c. County of Deat	
Fund			5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth  Month, Day, Yea,  Jan. 31,	g. Bir	thplace (State or Foreign
A	_	<u>-</u>	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		Jan. Ji,		10d. Inside City Limits
Marylar 28a-f s	otified	irecto	Maryland Frederick	Frederic					YO Yes 2 No
with the	ust be n	Funeral Director	10e. Street and Number 7407 Willow Road		10f. Zip Code 2170	2	10g. [	Citizen of What Co $J.S.A.$	ountry?
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show	l Examiner m	5	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent if Armed Forces?  1 □ Yes 2 ※ If Yes, Give Year or Dates.	iver in U.S. 13. 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (Specifin, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o	Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 8	(Give life. D	O NOT use retired)	ation during most of working	1	. Kind of Business	Industry
iled with Hygien other th	ent, the	Be	17. Father's Name (First, Middle, Last)	H	Iomemaker	18. Mother's Name (F Ada Lee		n Home on Surname)	
Irylar buld be f d Menta marked	matic e	욘	Charles C. Vaughn  19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Addross (Street	Ada Lee			Code) 21702
hind 2 sho lealth an im 27 is	her trau		Mrs. Nena Eyler, PR	201 T	Thomas Jol	hnson Dr.,	Suite 10	01, Frede	erick, MD
Baltimore, Maryland 212 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other th.	ury or ot		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Mount 01	osition (Name of matory or other place ivet Ceme	etery Dec.	16, 2009	. Location - City or Freder	rick, MD
Balt permit. Departi Import	any inj once.		21. Signature of Funeral Service Lasee MOC	) 255 1	eeney and 06 East (	l°BasTord E Church St.,	PA Funera Frederi	1 Home .ck, MD 2	1701
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each of Immediate Cause (Final		er the mode of dyin		espiratory arrest,		Approximate Interval Between Onset and Death
⊷Pπysici Med Exåmi	lical		disease or condition resulting in death)  a. Due to (or as	a consequence of):	yaro,	1 Denni	enua		
		iner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying	а полведиелов 66:					
760 icate be executed physician and	al-transi	Examiner	Cause (Disease or linjury that initiated events c.	a consequence of):					
760 icate be e	the bur	Medical	d						
Box 68 death certif	thed for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
Records, P.O. The law requires that the ate has been signed by the	huld be detac	ted by Pr	Part II. Other significant conditions contributing to death by Hyper Henourn	ut not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tobacc	^ _	the cause of death?
Vital Records, ysician: The law requires is certificate has been significate has been significant to the significant to	page 2 sho	Somple			_		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
/ital /sician: s certific	director,		25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Input	ent 2 🗆 ER/Outpatier	Oth	er:		6 ☐ Other (Spec	ifu)
n of ding Phy h. After thi	funeral		27. Magner of ath 28a. Date of inju (Month, Da	ry 28b. Time of	f 28c. Injury work	y at 280	d. Describe how in		,,
Division of tal or Attending Ples after death.	in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuiting, etc.	ury - At home, farm, str c. (Specify)			f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific	eted filled	Medical	29a. Certifier Check Che	xamination and/or inves	stigation, in my opinio	on, death occurred at the	e time, date and pla	ace, and due to the	cause(s) and manner stated.
To the within To the	comple	Σ	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and fittle of certifier	best of my knowledge,	29c. License		29d.	Date signed (Monti	n, Day, Year)
			30. Name and address of person who completed cause of d	eath (Item 232) (Type, I	Print)	> 1/8-	5 De	ecember 1	+, 2009
0	Stat	e	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	300 U	19/ 9/	Stree	21 110	derich, m
Reg	gistra		DEC 1 7 2009 Level	A. Dort	3/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician ecember riannit 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F **Director** 212-50-8365 61 November 30, 1948 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director must be notified Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 8264 Arden Drive 21801 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be William Elmer Brown ည MaryAlice Urban 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Claude Hartman / Husband 8264 Arden Drive, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 10, 1 XBurial 2 Cremation 3 Removal from State Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Point of Rocks, Maryland 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 E. Church Street, Frederick, Maryland 21701 MO1473 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, ding physiciar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 1 Tyes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 2 Accident 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Moo)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

06672

2009

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 29, **Physician** 2009 4:30 am Leslie Alexander Hardware, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2119 Falling Creek Road Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Hours Months Min. Jamaica, W.I. 94 12/31/1914 Director 579-88-5611 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 2119 Falling Creek Road 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify þ 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Building & Construction Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Alexander Hardware Celestina Stewart ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreen P. Hardware - Daughter 2119 Falling Creek Road, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 12/10/2009 Olney, Maryland 5 ☐ Other (Specify) Norbeck Mem. Park 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens M00709 Josey M. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ve. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unknown **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Kidney Disease 24a. Was an autopsy 2 💢 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) ြို 1 ☐ Yes 2 X No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D61007 November 30. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12520 Prosperity Dr., #320, Silver Spring, MD 20904 Dr. Khandagle, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **DEC** 0.3 2009 Registrar

DHMH 17 Rev 1/2001

09-09651

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IDhn Henrici	State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg, No. 2009
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  December 11, 2009  2. Date of Death  2. Date of Death  Annuth  Day  Year  December 11, 2009
meardar Examiner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
1	404 Blue Silk Lane Apt. C Montgomery Village Montgomery  5 Social Security Number 16 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	047-32-0575   TXM 2 F 75 Yrs.   Months Days Hours Min.   March 20,1934   Country) PA
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
3	Maryland Montgomery Gaithersburg 1 X Yes 2 N
	10e. Street and Number  404 Blue Silk Lane, Unit C  10f. Zip Code  10g. Citizen of What Country?  USA
er death with or items 23 r must be no Funeral	11. Marital Status 1 Never Married 2XX Married 2XX Married 2 XX Marrie
frer der Fr, or i Frund / Fu	3 Widowed 4 Divorced If Yes, 1956-59 1 Yes 2 No specify: Specify: White
nours after natural" (xamine	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)
5-0036 ed within 72 hour stygiene. other than "natur the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Sales Executive Encyclopedia
5-00; ed with tygiene other t he Me	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
1218 be fill ental H arked vent, t	John Henrici Margaret Zardus
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Complé	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  John J. Henrici/Son  1616 Overlook Drive, Silver Spring, MD 20903
e, M l and 2 Health item 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
MOF Pages   ent of   int: If	1 Burial 2 **Cremation 3 Removal from State Metropolitan Crematory Dec. 14 4 Donation 5 Other Specify:  Alexandria, Virginia
Baltimore, permit. Pages I an Department of Her Important: If ite Important: If ite injury or other tr	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 200
	23a Part   Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   Approximate Inter-
Physician /Medical	failure. List only one cause on each line.  Atherosclerotic cardiovascular disease  Death  Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated
uted id ansit	events resulting in death). Last
60, ate be executed hysician and e burial - transit	X AMENDED 23a,27,perm,E g900 2/18/10 TT #21 per Fh g898 12/18/09 TT
box 68760, the death certificate be executed the attending physician and ched for use as the burial - transi Physician/Medical E.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687 e death certifice the attending p ed for use as th	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
Vital Records, P.O. Box 6876 hysician: The law requires that the death certificat this certificate has been signed by the attending phil director, page 2 should be detached for use as the To Be Completed by Physician/IM	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
P.O. P.O. S that the stratt the s	1 Yes 2 ✔ No 3 Probably 4 Unknow
Records, P. ( The law requires tha ficate has been signed , page 2 should be det Completed by	24a. Was an 24b. Were autopsy findings avails autopsy prior to completion of cause
ecor ne law te has l	autosy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
al Re	25. Was case referred to medical 26.Place of Death (Check only one)
Division of Vital Records, fal or Attending Physician: The law requirers after death.  "I Director: After this certificate has been selled in by the funeral director, page 2 should bertification: To Be Completed.	1 Ves 2 No Impatient 2 ER/Outpatient 3 DOA 4 Norsing nome 5 Residence 6 Vine. Scene
n of oding Planera E funera	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28b. Time of Injury 1 Yes 2 No
isio	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Control of Town State)
Division of N spiral or Attending Ph, rours after death. neral Director: After tr filled in by the funeral Certification: T	3 Suicide 6 Could not be determined (Specify) or Town, State)
Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: / **completely filled in by the filled in Contification	
	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
2t'	O.C.M.E. December 12, 2009
	30. Name and address of person his completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	
State Registra	nro 1 / 2000   /2 // ///////

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mae Hooks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Nicomic 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Months (Month, Day, Year) 42 Director Virginia 29 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner miret has marked and 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Princess 1 Yes 2 No Somerset Anne Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 1974 Edgehill U.S. lerrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private family Home 10th grade Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unknown Dorothy Westfall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Andrew Hooks - Son Burgess Taylorsville 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 11-19-09 Princess Anne. Beechwood Cemetery 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Anthony E. Ward foreral Home E. Ward 30634 Hampolen Ave Princess Anne, md 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ACCIDENT CRRBBROVASCULA Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s autonsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? PNO. Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and http? of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6Hunsun 2/801 WAN 31. Date filed (Month, Day, Year) 32. Registr State

DHMH 17 Rev 7/2009

Registrar

NOV 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Atwood Hubbard 2009 VOV /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth January 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Massachusetts 1 ▼ M 2 □ F 87 026-01-5841 **Director** Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marnent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f st.
Into or other traumatic event, the Medical Examirer must be realised. 1 ☐ Yes 2 ▼ No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8517 Pineway Drive 20723 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervision Field Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark A. Hubbard Rosamond Perry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesley Jean Hubbard - Wife 8517 Pineway Drive, Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If I 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Atlantic Crematory, Inc. 11/30/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 21. Signature of Funeral Service Acensee nic 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Aspiration pheumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebral Vascular Accident Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Athal Fibrillation Due to (or as a consequence of): Box 68760, attending pl IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Day 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes a No Certification: To 1; Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

31. Date filed (Month, Day, Year)

DEC 01 2009

Srilatha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanumuvu



Cedar

Lane

Columbia, mr 21044

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 24,200 NADINE 4a. Facility Name (If not institution, give street and number), PICAS ONT VIEW NUTSING: Home 4.00010 NQ+10001 4c. County of Death 4b. City, Town, or Location of Death arrol MOUHT AIRY If Under 24 Hrs. 8. Date of Birth (Month, Pay, Jul 7, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 X F 1940 Maryland 212-40-7011 69 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Union Bridge Carroll Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21791 USA 105 South Lightner St 14 Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify white Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publishing Co Warehouse Worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beulah V. Keefer Jennings Frock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2037 B Don Ave, Westminster, MD 21157 Tina L. Ray, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/28/2009 Pipe Creek Cemetery Union Bridge, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 136 E Baltimore St, Taneytown, MD 21787 ust Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final Metastsho -3 months disease or condition resulting in death) Due to (or as a consequence of) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Ebrilation Atrial Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months' Month

Physician /Medical Examiner Examiner the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at

the state of

death with the

hours after

within 72 h

d 2 should be filed within the and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev

Pages 1

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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burial-transit and attending physiclan for use as the buria ian/Medical ed by the a s been signed to should be deta certificate has t irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

WJL 3

Physic	1 ☐ Yes 2 ☐ No 9 ☐ Hiknown	4∐Pregnant at time of death 9⊡⊌nknown	5 ☐ Other (sp	ecify)					
by			in the underlying o	ause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
Completed					24a. Was an autopsy performed 1□ Yes 2 🗹				
ø	25. Was case referred to medical			26. Place of Dea	th (Check only one)				
To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DC	Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)			
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	D. Time of 2 Injury M	Rc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
Certifica	3 ☐ Suicide 6 ☐ Could not be determined		farm, street, factory	28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
edical (		hysician: To the best of my knowled miner: On the basis of examination and manner stated.							
₩.	20h Signature and title of certifier		290	License number	294	Date signed (Month, Day, Year)			

State Registrar

31. Date filed (Month, Day, Year)

NOV 30

wouldnum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOULCAH 32. Registrar's Signature

par

1534

Dio 64911 11/25/2 509 WING WILLIAM ON CATHONILLE - M

. DOY OO!		Daltiillole, iilal ylalla 21213-0030
e death certificate be executed	Ph /N Ex	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary
	ys Me	Department of Health and Mental Hygiene.
he attending physician and	sio ed mi	Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sh
ed for use as the burial-transit	cia ic:	any injury or other traumatic event, the Wedical Evandor oust be notified
	a e	

			1 - State Registrar		Cer	tificate of	Death		Reg. No. 2009 4029		
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De	Day Vear	3. Time of Death	
	Physici /Medio		Laurie Jean Rath	bun Hoover				Novembe	er 30, 2009	7:20 PM	
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)			or Location of Death		4c. County of De		
18			2916 Peebles Court	17.4		Olney If Under 1 Year	If Under 24 Hrs	o Data of Riv	Montgome		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la vi 2🗓 F 53	st birthday) _ Yrs.	Months Days		8. Date of Bir (Month, Da	ly, Year)	irthplace (State or Foreign Country)	
	Director		093-44-6105 Usual Residence of Decedent	33	1.01			Aug 20	, 1956 New	v York	
	land ow		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits	
	Mary	to	MD Montgomer	y Olne	V					1 □ Yes 2 No	
	r 28g	ie	10e. Street and Number	- 1	4	10f. Zip Code			10g. Citizen of What C	Country?	
	h witi	a D	2916 Peebles Court			20832			USA		
	deat	Funeral Director	11. Marital Status	. Was Decedent Ever in U.S Armed Forces?	. 13. W	as Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No	- 14. Race - An Black, Wh		
98	after or it		1 Never Married 2 Married	1 XYes 2 No		□Yes 2 XNo		r tieding overly			
003	ural",	d by	3 Widowed 4 XDivorced	Year or Dates: 1981-	96				Specify: Wh		
21215-0036	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the M. deal Ezain her i ust be notified at	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	16a. Decede	ent's Usual Occu aind of work done	ipation during most of worki ed)	ing	16b. Kind of Busines	s/Industry	
12	withir ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		ered Nu			Healthcare	<u> </u>	
CA	filed Hygi other ent,		17. Father's Name (First, Middle, Last)	•	1109100	.crca ma	1	(First, Middle,	Maiden Surname)		
an	d be ental ked c	o Be	James Ernest Rathb	un			Carol Eve	lyn Var	Patten		
Maryland	should I and Men s marke umatic	မ	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Stree			er, City or Town, State,	, Zip Code)	
	and 2 ealth a n 27 Is		Cynthia Ann Hagstr	om/Partner	2916	Peebles	Court Oln	ev. MD	20832		
ē,	s1a of Hear item		20a. Method of Disposition	20b. Pia		ition (Name of atory or other pla		Date	20c. Location - City of	or Town, State	
E	Page net c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	noval from State			natory 12/	04/09	Woodbine,	MD	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exam.		21. Signature of Funeral Service Licensee	11/1					ce P.O. E		
ω	89 <b>58</b>		Beverly I the	Little MOI						le, MD 21029	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused the death.	Do not ente	r the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Ovarian Canc	er					Onset and Death	
	/Medical		resulting in death)	Due to (or as a conseque							
	Examiner	_	Sequentially list conditions, b.								
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	xecut and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit										
387	ficate phys s the	Medical	d.								
×	certii nding ise aa	_	IF FEMALE: 23b. Was decedent pregnant	. If <u>ye</u> s, outcome of <u>pregnan</u>	су				23d. Date of d	lelivery	
Bo	leath atte	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de	death 3□	Ectopic pregnan Other (specify) _	су		Month	Day Year	
P.O.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician	9 Unknown	9 Unknown							
Э,	res that signed I be deta		Part II. Other significant conditions control	ibuting to death but not result	ting in the une	derlying cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?	
Records,	w require been sig should b	Completed by						1 🗆 '	Yes 2X No 3□	Probably 4 Unknown	
ပ္က	aw re ts be 2 sho	plet						24a. Was	an 24b. Were	autopsy findings available o completion of cause of	
æ	: The law icate has t ; page 2 s	E O						perfo	rmed?   death	es 2 No	
of Vital	slcian: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Deatl				
	nysic direc		examiner? 1 ☐ Yes 2 🛣 No Ho	spital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 □ DOA Ot	her: 4  Nursing Ho	me 5 <b>∏⁄</b> Resi	dence 6 ☐ Other (Sp	pecify)	
0 _	ng Phy fter thi neral c	Ë.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wo	ury at ork?	28d. Describe	how injury occurred		
Sio	endi eath. or: A	ati	2 ☐ Accident investigation			M 1 [	]Yes 2□No				
Division	or Att fter d irect n by	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or To	Street and Number or i wn, State)	Rural Route Number,	
	s a sa	ပ္ပ	29a. Certifier 1 X Certifying Physic	cian: To the best of my know			*				
	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			r: On the basis of examinati	on and/or inv	estigation, in my	opinion, death occur	red at the time,	date and place, and d	ue to the cause(s)	
	Hospit 24 hour Funera etely fill		(Check only one)	and manner stated.							
	Fo the Hospit within 24 hour Fo the Funer completely fill	Medical	(Check only 2 Medical Examine			29c. Licen	se number		29d. Date signed (Mo.	nth, Day, Year)	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera		(Check only 2   Medical Examine			29c. Licen D631 9			29d. Date signed (Mo. December 1		
			(Check only 2   Medical Examine	and manner stated.	23a) (Type, P	D6319					
	To the Hospin 24 hour within 24 hour To the Funer completely fill		29b. Signature and title of confiler	and manner stated.  HD  pleted cause of death (Item)		D6319			December 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Orpo 0 Medical 4b. City, Town, or Location of Death **Examiner** County of Death 8. Date of Birth (Month, Day, Year) Feb 23, 1929 **Funeral** 1 🗆 M 2 🗶 F Months 197-22-5137 **Director** 80 Pennsylvania Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 X Yes 2 ☐ No DC Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral USA 20015 6113 32nd Place NW 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White "natural" 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clinical Director Secretary NTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျပ Homer Goodman Bridget Elizabeth Fray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6113 32nd Place NW, Washington, D.C. 20015 Mark Hipsley/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 11/29/09 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 10 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Dunto (cras a consequino of) cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trar burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Box 1 Live Birth
4 Pregnant
9 Unknown Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Physician: The law requires that the death Month Vear Day Pregnant at time of death been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Records, Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c 욘 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Hospital or Attending 5 Pending work? Divísion 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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completed cause of dea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 40301 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 30, 2009 12:20 рм <u>Donald M. Harkins</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard 9322 Michaels Way Ellicott City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🌠 M 2 🗆 F Months Days Hours Min 87 216-16-8229 Director Usual Residence of Decedent Department of Health and Mental Hygiene.
Important: If the 27 is marked other than "north any or other than the marked other than "north any or other than the marked other than "north any or other than than "north any or other than "north any or 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 9322 Michaels Wav 21042 United States 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married ģ 1 X Yes 2 If Yes, Give Year or Dates. White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles M. Harkins Ruth Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9322 Michaels Way Ellicott City, MD Naomi L. Harkins - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Denation 5 Other (Specify) Lakeview Memorial 12/04/2009 Eldersburg, MD 21. Sign turi Funeral 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M01411 CL 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner E squantiary list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed clause of death (item 23a) (Type, Print) Ridge Rd. #103, Ellicott City, MD 21042 2850 N.

State

Registrar

M.D

2009

Registrar's Signature

Kathleen York—Jordan

31. Date filed (Month, Day, Year,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L		Mental Hygier	711117	40302
Physici /Medio		Decedent's Name (First, Middle, L CHARLES ARTHU	•	VES			2. Date of Death NOV. 25	2009 Yeer	3. Time of Death 6:30 P M
Examir		4a. Facility Name ( <i>If not institution, g</i> Woodlands at Ke	nsington P	ark	Kensi	Location of Death ngton		4c. County of Death Montgomer	
Funeral Director		513-12-5167	. Sex 11XM 2□ F 7. A	ge (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 13	9. Birth Cou 1924 Mi	place (State or Foreign ntry) LSSOURI
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Inportent: If item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Macical Examiner must be rightly at QDCe.	ector	Usual Residence of Decedent  10a. State  10b. County  Md . Montg	omery	10c. City, Town or L Laytor	nsville		100	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
23e or 2 ust be m	rai Dire	10e. Street and Number 23911 Laytonsvi	lle Road		10f. Zip Code	20882		United S	States
urs affer dea al', or items Examiner M	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 New 2 In the State of St	No WWII	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 Who	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, Specify:	
within 72 ho ene. than "natur he Medical I	ompleted	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+) (Give	edent's Usual Occupa e kind of work done of DO NOT use retired ncer Resea	during most of work )	king	. Kind of Business/Ir	
ould be med Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, La Albert Wellin	gton Harg	reaves		18. Mother's Nam Hazel	e (First, Middle, Maio Elizabetl	n Newland	
alth and 27 is my rtaume		19a. Informant's Name/Relationship Donald C. Hargr					ral Route Number, Cito ad, German		
Pages 1 a lent of Hea nt: ffitam ry or otha		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  4 □ Donation 5 □ Other (Spe		•	osition (Name of omatory or other place itan Crem.	θ)		. Location - City or T Alexandria	
permit. Departm Importa eny inju		21. Signature of Funeral Service Li	norte	2	2. Name and Address Muriel H P. O. Bo	Barber ox 5038,	Funeral Ho Laytonsvi	ome lle, Md. 2	20882
Medical way when the purial-transit the purial-tran	lical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. BL  Due to (or as  b. AD  Due to (or as	ADDER CANC: s a consequence of): VANCED DEM: s a consequence of): s a consequence of):					Interval Between Onset and Death
ins law requires that the usean centificate by executed as the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliving Month	very Day Year
w requires that it is to be a signed by should be detailed as the state of the should be detailed to the should be detaile	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to 2⊠No 3 ☐ Pro	
	Completed						24a. Was an autopsy performed 1  Yes 2	prior to co death?	opsy findings available ompletion of cause of 2 No
To the Hospitel or Attending Prysicien: In within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	t be 28e. Place of Ir	iury 28b. Time	of 28c. Injur Worl M 1	er. 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S	njury occurred t and Number or Rui	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer		Physicien: To the best saminer: On the basis and manners	of examination and/or i					
vithin : To the comple	Mec	29b. Signature and title of certifier	aljona	~ ~	29c. Licens	2766		Date signed (Month	, Day, Year)
0+1		30. Name and address of person with ALPANA GOSWAMI		death (Item 23a) (Type 11125 ROCK)	Print)  /ILLE PIKE	E, #110,	ROCKVILLE,	MD. 2085	52
Sta Regist	ate rar	31. Date filed (Month, Day, Year)		tras Signature	park	,			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Division or Vital Records, P.O. Box 68760,

Neptune, New Jersey 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No Hospital or Attending Physician: 24 hours after death. Certification: after death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca To the l within 2. To the l and manner stated. 29d. Date signed (Month, Day, Year) 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ellar D. Rockville, MD 20850 4AD 10110 MYEU 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a,26 per verb , 2898,12/17/09dhb

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 2009 Month **Physician** James Kidd Humphreys II 10:20 am Novembe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner a Plata NISTA Med Social Security Number Center Medica If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days XXM 2□ F Months 207-36-7462 60 Director DEC.31,1948 W. Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, it as Medical Examinat must be notified at 1X X es 2 □ No Director MD Charles La Plata 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1331 Redwood Circle 20646 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※ No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENVIRONMENTAL PROG.MGR. U.S.Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be and Mental Clayton Humphreys Phyllis Jean High မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Jean Humphreys/Spouse Redwood Circle La Plata, MD 20646 1331 Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition DECEMBER Pages 1 5 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State ANDREWS MORTUARY 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) WILMINGTON, NC 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service Licen Lours 1800 M00641 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the cause of the death. Approximate Interval Between Onset and Death Cardiovascu Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Due to (or as a co Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 \( \subseteq \text{ Ectopic pregnancy} \) ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2X No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Manner of Death
Natural
Accident 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely the within To the 29d. Date signed (Month, Day, Year) 29b. Signature 0061652

State Registrar 30. Name and address of pe

31. Date filed (Month, Day,

Year)

17

Suite 101 Waldorf MD

leted cause of death (Item 23a) (Type, Print)

09-09505 Lily Mae Jones		Ple	ase Type Stat	<b>or Print in</b> e of Maryla	Black In	i <b>delible</b> l artment c	I <b>nk. Ensu</b> of Health ar	r <b>e All C</b> nd Ment	<b>opies A</b> tal Hygie	re Legil ene	_	nno	40305
	F	I- For State Registrar			Cei	rtificate c	of Death		12 D	Reg.	No.		Time of Death
Physiciar Medical Examine	0.6	1. Decedent's Nam	e (First, Middle,L E JONES							onth Death ecember 6	ay Year , 2009		1703 hrs
, )		4a. Facility Name (i	f not institution, gunty General		mber)	J	4b. City, Town, o	r Location o	of Death		4c. County of Howard	Death	
Funeral	7	5. Social Security N		·	7. Age (In yrs. I	ast birthday)	If Under 1 Ye			Date of Birth(	MM/DD/YYYY)	9. Birthpla	ace (State or
Director		218-68-		M 2 XF	52	Y	Months Da	ys Hours		7/01/1		Countr	y) MD
any	ŀ	Usual Residence o 10a. State	10b. County		10c. City	, Town or Loca	ation						d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show must be notified at once.	اة	MD	Howard		Col	umbia	Total and			140-	Cities of Miles		Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu					10f. Zip Code				Citizen of Wha	t Country	
with th	ral	11. Marital Status	edar Lan	12. Was Dec	edent Ever in U	I.S. 13. W	21044	lispanic Orig	gin? ( Specify	Yes or No-	USA 14. Race - White,		Indian, Black,
r death or iter	Funeral		ed 2 Marri	1 X Yes	2 No		Yes, specify Cub			n, etc.)	Specify:	Blac	~k
urs afte	a	3 Widowed  15. Decedent's Ed		or Dates:  only highest grad		16a. Deced	ent's Usual Occup	ation (Give	kind of work	done 1	6b. Kind of Bus		
6 n 72 ho an "na ical Ex	etec	Elementary/Sec	ondary (0-12)	College (1	-4 or 5+)		most of working li		use retired)		bact. to II	Co I	Hognital
5-0036 iled within 77 Hygiene. I other than the Medica	Completed	17. Father's Name	(First, Middle, La	1 ast)		Regis	tered Nu		r's Name (Firs		iden Surname)	CO. 1	Hospital
1215 be file ental Hy irked o	å		E. Jone						tha E.				
MD 21 tid 2 should 3 tith and Men m 27 is man aumatic ev	٩	19a. Informant's Na Russell		o (Type, Print ) brother			ing Address (Str Harriet						
e, M I and 2 Health item 2	ŀ	20a. Method of Dis	position		20b.		osition (Name of		Da	•	20c. Location -		
Baltimore, permit. Pages I ar Department of the Important: If the Injury or other tr		1 X Burial 2	Cremation Other Spec	3 Removal fro	om State	pkins	UMC Cem.		12/14		Highlan		D
Balti Sermit. Separtn Import		21. July ture of Fu	ineral Se vide Li	c ne e	1		Name and Address						1850
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Box 68760, e death certificate be ex the attending physician ed for use as the burial	sician/Medic	IF FEMALE: 23b. Was decedent past 12 month	s?	23c. If yes, 1 Live b	outcome of pre	gnancy 2	Fetal death Other (Specify)		ic pregnancy		23d. Date of Month	delivery Day	Year
Box he death of the atter	Phys	1 Yes 2 V		9 Olikik				e given in P	Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
P.O. es that the igned by oe detac	ā	Tarrii. Other sign	mount bondies	iio contributing to	o death bat hot	Tooding in the				1 Yes	2 No 3	Probab	ly 4 🗸 Unknown
of Vital Records, P.O. Box ing Physician: The law requires that the death After this certificate has been signed by the atte uneral director, page 2 should be detached for u	Completed			· · · · · · · · · · · · · · · · · · ·						24a. Was ar autops perform	y p ned? d		osy findings available inpletion of cause of
al Re an: Th ertificat	ψ	25. Was case refe	rred to medical				26.Pla		(Check only			V 100	
of Vital ng Physician: ther this certif	TO B	examiner?	2 No		Inpatient 2			Other ₄	Nursing H		esidence 6	Other:	
on of nding I th.		27. Manner of Dea	5 Pendir		of Injury n, Day,Year)	28b. Time		Yes 2	_	u. Describe in	w nijary occur	ou.	
Division of Vital Rec Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate I tely filled in by the funeral director, page	ertification:	2 Accident 3 Suicide	Investi 6 Could determ	not be 28e. Plac		home, farm, s	treet, factory, offic	e building, e	etc. 28f	f. Location (St or Town, Sta		er or Rural	Route Number, City
S = 5	O	4 Homicide	Certifying Phy	rsician: To the he	st of my knowle	edge, death oc	curred at the time	date and p	lace, and due	e to the cause	(s) and manner	as stated	
To the Hos within 24 h To the Fur	Medical		Medical Exam	iner:On the basis	of examination	and/or investi	gation, in my opin	ion, death o	occurred at the	e time, date a	nd place, and d	ue to the o	cause(s)
	Σ	and manner stated.  29b. Signature and title of certifier						ense numbe C.M.E.	er .		29d. Date sign.  December		
	30. Name and address of person yno completed cause of death (Item 23a)												
		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201											
Sta Registi	ate rar	31. Date filed (Mo)	th, Day, Year) (C 14 20	109 Sene	egistrar's Sign	fure	N.S.	·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0:20 R M December Robert Booth Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Perry Point VA Medical Center Perry Point Ceci1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral XX**M 2□ F **Director** 4, 1933 Maryland 216-28-8332 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXVo Director Winter Springs Florida Seminole 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 139 Columbus Circle 32708 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐XYes 2 ☐ No If Yes, Give AjF2F0756 Year or Dates1952F0756 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2√2√No <u>ک</u> Specify: White 3 TWidowed 4 Divorced "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ealth and Mental I n 27 Is marked ott John F. Johnson, Jr. Elizabeth Booth ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Johnson/Ex-Wife 139 Columbus Circle, Winter Springs, Florida 32708 other Department of Heal Important If Item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4, 2009 North East, Maryland 21. Signature of Funeral Service Licensee Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WG wantons disease or condition resulting in death) /Medical Div to (or as a consequence of): **Examiner** Secus idally flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown n signed by tl Part LOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed distant 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

after death. completely filled in by the I 24 hours a

> 31. Date filed (Month, Day, Year State DEC 0 3 2009 Registrar

4 Homicide

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CECIA

and manner stated.

determined

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

MANJAND 21903

	1 - For State Registrar				Cer	rtment of tificate o	Death			Reg. No.		) J	030
	1. Decedent's Name (First, Middle	, Last)						-	2. Date of D Month	eath Day	y Yea		me of Death
an cal	Justine Jor	ies									29, 20		1:15P ^M
ner	4a. Facility Name (If not institution	, give street and	d number)			4b. City, Town	or Location	of Death		4c.	County of D	eath	
	Morningside Hou					Laure If Under 1 Yea		r 24 Hrs.	1000		rince		
	5. Social Security Number	6. Sex 1 □ M 2 1		(In yrs. last	Yrs.	Months Day		Min.	8. Date of B	Day, Year)		Country)	tate or Foreign
	200-05-8934 Usual Residence of Decedent			93					July	18, 1	1916 P	ennsyl	vanıa_
	10a. State 10b. County		1	I Oc. City, To	own or Loc	cation						10d. Insi	de City Limits
Director	Maryland Princ	e Georg	es	Be1t	tsvil	.1e				1 □Yes 2 🕅			
	10e. Street and Number					10f. Zip Code				10g. Cit	izen of What	Country?	
	12501 01d Gunpo					2070	5			US	SA		
nicial	11. Marital Status	Arme	Decedent Event Eve		13. V	Vas Decedent o f Yes, specify Cu	f Hispanic O Iban, Mexica	rigin? (Sp in, Puerto	pecify Yes or N Rican, etc.)	lo-	14. Race - A Black, W		an,
ý	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes	es 2 XNo , Give or Dates:		1	□Yes 2∏ N	o Specify	<i>'</i> :			Specify:	Whit	e
3	15. Decedent		or Dates.	10	6a. Deced	lent's Usual Occ	upation			16b. Ki	ind of Busine	ss/Industry	
<u> </u>	(Specify only highes	t grade comple	ted) ge (1-4or 5+)		(Give I	kind of work dor DO NOT use reti	e during mo	st of work	king				
completed	12	Colleg	go (1-401 0+)		Clerk					Dis	strict	Photo	S
מ	17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Middl	le, Maiden	Surname)		
	Pete Pronko						Mil	ldred	l Chan	as			
	19a. Informant's Name/Relationsh					g Address (Stre						e, Zip Code)	
	Michael Jones-	SON				Shadow	Lane			т			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal fi	rom State	20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other p	lace)		Dat <i>e</i>	20c. Lo	ocation - City	or Iown, Sta	ate
	4 Donation 5 □Other (Sp			Ivy	U-111	0		10/2	///	T can	iral 1	Maryla	- 1
	23a. Part 1. Enter the disease, or shock, or heart failure. List	MO / L complications to	nat caused th on each line.	ne death. D	76 Do not ente		ress of Faci eral I	lome,	INC,			y land Appro Intervi	
	snock, or neart failure. List Immediate Cause (Final disease or condition resulting in death)  Seguentially list conditions.	complications the control one cause	rat caused the content on each line.  Fail:  to (or as a content of the content o	ure to	76 Oo not enter o Thr ce of): Arter	Name and Add eck Fun 01 Sand er the mode of c	dress of Faci eral I y Spri ying, such a	ity Iome,	INC,			y land Appro Intervi	20707 ximate al Between
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State Registrar Dr. Baig, M.D.

31. Date filed (Month, Day, Year)

DEC 01 2

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DHMH 17 Rev 1/2001

Avenue, Laurel, Maryland

20708

13900 Baltimore
32. P gistrar's Signature

2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, 2009 Month **Physician** 3:45 PM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □XF 190-16-6997 85 Sept 16. 1924 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3409 St. Leonards Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 2X No If Yes, Give Year or Dates: Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, The M Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Keil Robert Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Jones/husband 3409 St. Leonards Ct. Silver Spring, MD 20906 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 12/03/09 | Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAUS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 [] NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

be executed burial-transi and P.O. Box 68760, physician the the attending pl hed for use as t signed by the a Division of Vital Records, peen has page 2 certificate Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

28a-f show

within 72 hours after death

Baltimore, Maryland 21215-0036

Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 0057630

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anur Acha

State Registrar 31. Date filed (Month, Day,

Registrar's Signatur

12

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Mar		artment of F rtificate of l			ene g.No. 2 A A C	1.0200
			1. Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Beath
н	Physicia /Medic		Ruth Gray Johns	on				November	r 23, 2009	
-	Examin		4a. Facility Name (If not institution, giv	_			Location of Death		4c. County of Dear	
uga 1º	0		Suburban Hospita  5. Social Security Number 6. S		'In yrs. last birthday)	Betheso	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director			□ <b>™</b>	99 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	חדויין	thplace (State or Foreign buntry) nesota
	ס		Usual Residence of Decedent					T7=10=1	.90 9	10d. Inside City Limits
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Mydral Examinat must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2X No If Yes, Give Year or Dates:		1 □Yes 2X□No	Specify:	Titoan, etc.)	Specify: Wh	
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<u>la</u> n	ld be lental rked c	To Be	George Gray				Claire	Maud Lyn	ch	
ary	and Nand Serven		19a. Informant's Name/Relationship (	Type. Print) Daugh	ter 19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
Σ,	and 2 ealth n 27 i		Jeanette L. John	son/-in-law	2934				ington, DC	20008
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			Michael J. Grady 31. Date filed (Month, Day, Year)	MD 4201 Cat	thedral Av	ve. NW #1	14W Washi	ington, l	DC 20016	
	Sta Registi		TEC 0.2 20	na hour	's Signature	Charles .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ December Irma Kolodny 2009 2222 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 □ M 2 🕱 F Months Hours 02/05/1934 Director 128-26-0158 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😿 No Maryland Montgomery Silver Spring 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a o Examiner must be Funeral 8505 Springvale Road 20910 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces' þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Maryland 21215-0036 1 Yes 2 Y No Specify "natural" 3 Widowed 4 Divorced Completed Caucasian Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry New York City Board Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. of Education Personnel Analyst is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည 27 is marked r traumatic e Lillie Meltzer Jack Smith Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 Ritchie Avenue. Silver Spring. MD 20910 Debra Kolodny - Daughter Department of Health Important: If item 2; any injury or other tonce. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 12/7/2009 Brentwood. Maryland 4 Danation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License M0070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 Yes 2, No in 24 hours after death.

the Funeral Director: After this certific inpleted filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State

31 Date filed (Month, Day, Year

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Louise Kisamore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-RMC Cumberland Allegany 8. Date of Birth (Month, Day, Year) Jan 19, 1944 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ 😿 Months Days Hours Min. 217-40-5062 MD 65 Director Usual Residence of Decedent 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examity must be multiled at Allegany MD Cumberland Director 1 □¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Wenton Place 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 □No If Yes, Give Year or Dates: Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Maonce. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Anna Linke ပ္ 19a. Informant's Name/Relationship (Type. Print)
Gwendolyn Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 12012 Mulberry Avenue Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Zion Reformed Church Cemetery 12/8/2009 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility and Home, PA 21. Signature of Fundred Fervice Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the I∏Yes 2∏No detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The performe 1 ☐ Yes 2 No 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 □Yes 2 □ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

12500 WILLOWBRYOK RD CUMBERLAND MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAVROMATIS MD. 12.
Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per phys. G898 12/23/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 24, 2009 **Physician** MIKIO KATO 5:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1√□ M 2□ F Months Days Hours Director 065-30-0094 85 January 2, 1924 Japan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Funeral Director Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4308 Skipjack Lane 21817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by If Yes, Give Year or Dates: Specify: Japanese 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Obstetrician/Gynecologist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hirotada Kato Umeko (UNKNOWN) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Sue Kato (Wife) 4308 Skipjack Lane - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 12/4/09 Delmar, DE 21. Signature of uneral 22. Name and Address of Facility Service Licens Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshaw, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an has autopsy performed? page After this certificate Division or Vital 1 Yes 2√2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Lacritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 I 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State

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32. Registrar's Signature

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11805AM Month **Physician** Helen Kourkoules 2009 Decomse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner NONE TIMORE AGNES HUSPITAI If Under 24 Hrs. Date of Birth Month, Day 5/9/1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2 F New York 91 Director 216 32 9372 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show ral", or items 23a or 28a-f shov Examiner mast be notfilled at 1 ☐ Yes 2 No Director Catonsville Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 600 South Rolling Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examination. Black White etc. 1 ∐Yes 2 No. 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 🔼 o Specify. 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christina Unknown Peter Corines ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 106 19a. Informant's Name/Relationship (Type. Print) 2550 Kensington Gardens Ellicott City, Md. 21042 Nicholas Kourkoules/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greek Orthodox Cem. 12/7/2009 Woodlawn, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee Shem Co 4112 Old Columbia Pike Ellicott City, Md. 21043 MO1044 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) DEMENTIA Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine and The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physiclan a for use as the burial-1 Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð ATERAL 1 Yes 2 No 3 Probably 4 Ohknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed (SLITE certificate DIFF 1 ☐ Yes 2 ☐ No 1 □Yes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Impatient 2 ER/Outpatient 3 DOA 2 Division of this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital e Funeral I 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

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State Registrar

within 2 To the

29b. Signature and title of certifier

ROPOLÃO

31. Date filed (Month)

29c. License number

ROLLINGRO

29d. Date signed (Month, Day, Year)

STE 205 CATONIVILLE MD 21228

and manner stated.

516 N

32. Registrar's Signature

30. Name and address of person who completed cases of death (Item 23a) (Type, Print)

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	Physicia Medic		Francis Ku	hney							Month Novembe	r 28	^{ay} 2009	Year	6:15 a	М
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	Francis		Fairland Nursing Home  5. Social Security Number   6. Sex	7 Ac	ne (In vrs. Is	ast birthday)	Si If Under		Spring If Under		8. Date of Bir	_	Montgo		lace (State or F	Foreign
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	with tl 23a c 1st be	Funeral	16012 Wallingford Road					0904					ted St		. , .	
	items	Fun		12. Was Decedent Armed Forces?		3. 13. V			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Rac	e - America	,	
36	after o	by	1 Never Married 2 Married	1 Yes 2 X	No No		Yes				nicari, etc.,		Blac Specify:	ck, White, e	tc.	
21215-0036	atura cal Ex	Completed	3 Widowed 4 Divorced  15, Decedent's Edu	Year or Dates.		16a. Deced			17			104		ВТас		
715	an "na Media	mp	(Specify only highest grad Elementary/Seconday (0-12)		5.1	(Give k	and of wor NOT use	k done di	uring mosi	t of worki	ing	160.	Kina of B	usiness Ind	lustry	
212	withir giene ier tha		Elementary/Seconday (0-12)		5+	IT S _I	pecial	ist				St	ate De	epartme	ent	
nd	be filed within 72 hours after death with the Maryland ental Hygiene deathly hygiene deathly consturing the strong constitution and the material and constitute must be notified at its event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)								e (First, Middle,		Surname	e)		
r <u>yla</u>	uld be d Men marke natic	ř	George Francis Kuhr	-					Ju1i			iwaa				
Ma	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ	e, Pnnt)							<i>Route Numbe</i> er Sprin			•	ode)	
Baltimore, Maryland	1 and of Hea item other		Deanna Kuhney, wife 20a. Method of Disposition			lace of Dispos	sition (Nan	ne of			Date			- City or To	wn, State	
E O	Page nent o ant: If ary or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	²	emetery, crem e of Hea			1	12/12	2/2009	Silv	er Sp	ring,	Maryland	
alti	permit. Departn Importa any inju		21. Signature of Funeral Service Licenses			22	. Name an	d Addres	s of Facilit	y Hine	s-Rinald	i Fu	neral	Home,	Inc.	
_	20 <b>2</b>		Journ hoto		0707				-		nue, Silv		pring.	, MD 2	20904	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfalure. List only one cause on each line.  Immediate Cause (Final Onset and Death													
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	HMIA					- Control	INSTANT						
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):  RESPIRATORY FAILURE  Due to (or as a consequence of):							1				R 2	2 MONTHS	
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	cuted ind transit	xam	Cause (Disease or linjury that initiated events	c				(P)				M 1 1				
	Description of the part of the						3 3000	11	2 1	2						
760	cate b physi s the b	edical		l			1	-				1 4	1			
89	certifi nding use as	Z.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			1 =						23d. Da	te of delive	ry	
M = 00   II   I   TES Z L NO						Month Day Year										
P.O.	it the o	Phy	9 Unknown  Part II. Other significant conditions con		hut not roo	ulting in the cu	adarbiaa d	auga giv	on in Dort	1	00 0:11					
σ.	es tha signed be de	l by	SUBDURAL HEMATOMA	induting to death i	Dat Hot les	unting in the di	ilderlyllig (	ause givi	en in Fait			23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown				
ıds	requir been s should	Completed							24a, Was							
Division of Vital Records,	sician: The law is certificate has k irector, page 2 s	dmc	TRAUMATIC BRAIN INJURY						autopsy prior to completion of cause of death?							
<u>ھ</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical					26, Pla	ce of Dea	th (Check		2 4 1	No	1 U Yes	2 ∐ No	
Ĭ;	nding Physician: 1 tth. : After this certifice e funeral director, p	고 B	examiner? 1 ☒ Yes 2 ☐ No	ospital: 1  lnpat	ient 2 🗆	ER/Outpatien	26. Place of Death (Check only one)  Other: X  Other: 4 Nursing Home 5 Resi					sidence 6 Other (Specify)				
o	ing Pł		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ury ay, Year)	28b. Time of injury						d. Describe how injury occurred				
ion	ttendi death tor: A the fu	Certificate:	2 X Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	AUG 27, 2		8:15			Yes 2 X	No (	JOGGING AND STRUCK BY BICYCLE					
<u>i</u>	l or A after Direc	Cer	4 Homicide determined 28e. Place of Injury - At nome, farm, stre building, etc. (Specify)					, onice			City or To	Location (Street and Number or Rural Route Number, City or Town, State) RNER OF BONIFANT AND NEW HAMPSHIRE				
Δ	spita hours neral d fillec	Medical	29a. Certifier 1 X Certifying Physic							place, an	d due to the ca	ause(s) a	and mann	er as stated	d.	
	the Ho nin 24 the Fu	Med	(Check 2 Medical Examine only one) 3 Certifying Nurse													er stated.
	(, )		29b. Signature and title of certifier				290	. License						d (Month, E		
	JU I		fach					D28	656			NOVE	MBER	30, 20	09	
- (	3)		30. Name and address of person who co Ravi Passi, M.D., 152	,	,	, , , , ,		kvi11	e. Mar	rv1 an/	1 20850					
	Stat	e	Rav1 'Pass1, M.D., 152. 31. Date filed (Month, Day, Year) <b>DEC 02 2009</b>					*** T T T	rial e	утан	20000					
	Registra		<b>DEC 02 2009</b>	Cerus	J 13	Mar	Part of the same o									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, **Physician** 2009 November 0053 M Augusta Komarow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) 12/12/1920 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛱 F Months Days Hours 88 New York 053-12-5060 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery N. Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 1801 East Jefferson St., 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examiner. once. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Non Profit Organization 12 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Sophie Birnbaum Louis Klar ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20814 Jeffrey D. Komarow - Son 9511 Lindon Ave., Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ararat Cemetery 12/02/2009 Farmingdale. New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hines-Rincldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** daus Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined

COMPROW, A UGUSTA 11/30 09 0053 Division of Vital Records, P.O. Box 68760,

To the within 2

State

Registrar

Medical

29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MD D0060117 November 30. 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Park, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

DEC 02

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0520 Rembe Jovce Elaine Lane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 □ M 2 🗓 F Days Hours Country)
Maryland **Director** 214-36-0943 1938 Nov. Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 112 Fairground 21740 Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Bace - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) Service Representitive 12 Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ε. Purdham Mary M. Miller Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Alfred G. Fairground Ave. Hagerstown, Maryland 21740 _Lane /_Husband injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2009 Hagerstown, Maryland Rest Haven Cemetery 21. Sig ture f Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Altreroschoio cardio voscular Physician/ disease or condition Mins Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 42 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No this certificate 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAPI

32. Registrar Signatur

within To the

368 mill

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 12-9-09

Street Hagestorm ND 21740.

29c. License number **D 2 8 36**5

09-09492 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 40318 State of Maryland / Department of Health and Mental Hygiene Joseph William Lepore, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 6, 2009 1015 hrs **Medical Examiner** Joseph William LePore, Jr 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Caroline 18344 Lepore Road Marvdel If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Hours Davs Director 1 XM 2 F 67 Yrs 218-40-7145 Marvland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location Yes 2 No 28a-f show 'natural", or items 23a or 28a-f sho Examiner must be notified at once. Maryland Caroline Maryde1 death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18344 LePore Road 21649 .S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. Iani: If item 27 is marked other than "natural", on or other traumatic event, the Medical Examiner m 3 X Widowed Yes, Give Year 1961 Yes 2X No specify: Specify: White 4 Divorced ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 8 Warehouse worker Frozen Foods 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph William LePore, Sr. Pearl E. Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 16840 Henderson Rd. Lot 163, Henderson, MD 21640 John LePore/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ment : Greensboro Cemetery Dec 10 2009 Greensboro, Maryland Donation 5 Other Specify: permit. Name and Address of Facility 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home,
106 W. Sunset Ave. Greensboro, Mary 21. Signature of Funeral Service Licenses 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approx 21630 Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease **xamine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit ian/Medical X UNPENDED rttending physician or use as the burial 3a,27, permE g899 1/20/10 TT Box 68760, death certificate be 23d Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months Pregnant at time of death Physicia 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. icate has been signed by page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 🗸 2 No No Yes e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifictely filled in by the funeral director; 1 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other-Residence 6 V Other: Scene Inpatient ER/Outpatient 3 DOA Nursing Home 5 ۵ 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Yes 2 Pending Certificati 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. December 7, 2009 30. Name and address of person who completed cause of death (Item 23a)-

State Registrar

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M		epartment of I Certificate of		Mental Hy	gien 2 0 0 5	40319			
	Physici /Medic									3. Time of Death 710 P M			
	Examir		4a. Facility Name (If not institution, given 3330 North Leisu:		1vd #726		or Location of Dea Spring	th	4c. County of Do				
	Funeral Director		5. Social Security Number 6. S	Sex 7. Ag	je (In yrs. last birth		If Under 24 Hrs		th 9. Fay, Year) 2.4	Birthplace (State or Foreign Country) NY			
	Maryland I-f ehow	tor	Usual Residence of Decedent	mery	10c. City, Town Silver	or Location Spring				10d. Inside City Limits 1 X Yes 2 □ No			
	with the	Direc	10e. Street and Number 3330 North Leisu:	re World R	1vd #726	10f. Zip Code 2090	26		10g. Citizen of Whal	Country? States			
980	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow he Madical Ezami'ne must be notified a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Was If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or Norto Rican, etc.)	14. Race - A Black, W	merican Indian,			
21215-0036	within 72 ho ene. then "natur he Medical I	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) Coffege (1-4or:	5+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire ffice Manas	during most of wo	orking	16b. Kind of Busine				
Maryland 2	ould be filed Mental Hygie wrked other tatic event,	To Be Co	17. Father's Name (First, Middle, Last Herman Druck	)				- 1	o, Maiden Surname)				
	nd 2 shoilth and N 27 ie ma		19a. Informant's Name/Relationship (Robert Lieberman		19b. 29	Mailing Address (Stree The Saddle	t and Number or P Tallwood	dural Route Numb ls Villa	er, City or Town, State ge NSW2430	a, <i>Zip Cod</i> e) Australia			
Saltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other then 'a any injury or other traumatic event. Its was once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 ( 4 Donation 5 Other (Speci		cemetery	Disposition (Name of crematory or other plane) Mem. Garde		Date 4/2009	20c. Location - City Olney, MD	or Town, State			
Balt			21. Signature of Funeral Service Lice	nsee M	01163	22 Name and Addr 1170 Rocks	ess of Facility 7-Goldber 7ille Pik	g Memor	ille ^{Chap} 20	Inc 352			
8760,	Physician JMedical Examiner and physician and physician and physician and the physician and the physician and the physician and the physician and physician	Completed by Physician/Medical Examiner	23a. Fart. Enter the disease, or come shock or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Ch	1tisystem	n Organ Fai nphatic Leu ):	ilure	ac or respiratory a	rrest,	Approximate finterval Between 48 Hours Years			
P.O. Box 68	sicien: The law requires that the death certifical cartificate has been signed by the attending phirector, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnant 5 ☐ Other (specify)	су		23d. Date of Month	defivery Day Year			
			d by Ph	d by Ph	d by Ph	d by Ph	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying cause g	ven in Part I.		
Vital Records,		Complete						24a. Was auto pen 1 🗆 Yes	opsy prior ormed? deatl	autopsy findings available to completion of cause of 1? Yes 2 No			
Vita	Physician: rthis cartific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2 ER/Out	nation 3 DOA 0	hor	eath (Check only		inecity)			
Division of	Phy this al d	Certification; To	27. Manner of Death  1 X Naturaí 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of finjury M  28c. Injury al Work? 1   Yes 2   No				Home 5 XResidence 6 Other (Specify)  28d. Describe how injury occurred					
Divi	2552	Certifi	3 Suicide 6 Could not to determined	28e. Place of in	jury - At home, far tc. (Specify)	n, street, factory, office			(Street and Number of own, State)	Rural Route Number,			
	To the Hospital of within 24 hours at To the Funeral Completely filled in	edicai	29a. Certifier (Check only one) Certifying Plants 2 Medical Example 1	hysician: To the best miner: On the basis of and manner st	of examination and	death occurred at the look or investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) and manne , date and place, and	r as stated. due to the cause(s)			
	To the Vilhir Comp	Me	29b. Signature and title of certifier	40	•	29c. Licer D3474	se number +0	1	29d. Date signed (M November 30				
			30. Name and address of person who Robert Fields MD	18109 Pri	nce Phil:	ip Drive Su	ite 200	Olney MI	20832				
	Sta Regist		31. Date filed (Month, Day, Year) DEC 03 20	109 Regist	rar's Signature	pares							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 40320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vear Oliver Wendel 1045 AM Laird 2009 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death at the ospice Vicomico If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Months Hours 216-28-9971 Director 75 5-12-1934 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? Funeral 11290 Hayman Drive 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1  $\triangle$ Yes 2  $\bigcirc$  No If Yes, Give 1951–53 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Manager none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Jacob Irene Laird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11290 Hayman Drive, Princess Anne, MD Shirley Laird/wife 21853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 11-17-2009 Salisbury, Maryland gnature of Funeral Sep 22 Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave. Princess Anne Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tyes 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) examiner? 2/11/6 Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Marmer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUMAN 31. Date filed (Month, Day, Year) 32. Regia State **NOV 18** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Co. 200

			1- State of Maryland Department 24a per dr., g899,01/06/10 Celtificate	of Health and IV of Death	ientai Hygie Reg	ene 2009	40321
Physician			1. Decedent's Name (First, Middle, Last)  Harriet Ione LITTLETON		2. Date of Death Month December	5, 2009 Year	3. Time of Death
/Medical Examiner				wn, or Location of Death		4c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1.	Year I If Under 24 Hrs.	8. Date of Birth (Month, Day, Y August 7	9 Rirth	place (State or Foreign intry) Hampshire
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		August 7		10d. Inside City Limits
	Ba-f sho	ector	Maryland Washington Hagerstown				1⊠Yes 2 No
	th with the 23a or 2	<b>Funeral Director</b>	10e. Street and Number 910 St. Clair Street Apt #4 21	^{ode} 1742	10g	U.S.A.	intry?
980	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🕅 Married	nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto  No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  15. Decedent's Education (Give kind of work of life. DO NOT use if secretary) Secretary	done during most of work retired)	16	b. Kind of Business/li	·
nd	be filed ntal Hygi of other event, I	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Surname)	
Maryland	2 should to and Ment is marked raumatic e		Horatio Allin  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (S	Street and Number or Run	Mildred		in Cada)
	d 2 s th au t7 is trau			Oak Drive, H		•	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name cemetery, crematory or othe Hagerstown Crem	natory Decem		c. Location - City or T	
Ba	permit Depar Impor any in			Address of Facility Wilson Blv		Funeral Ho stown, Mar	ome ryland 21740
j	tificate be executed  Wedical Examiner as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	of dying, such as cardiac	or respiratory arresi		Approximate Interval Between Onset and Death
O. Box	eath cer attendir for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnant at time of death   5   Other (special pregnant at time of death   5   Other (spe			23d. Date of deliver Month	very Day Year
Records, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause  ( Manie Tellininatory failure	se given in Part I.	23e. Did tobac	the cause of death?	
_	10 11	Completed	Abdominal autic amenyo	) un	24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
<u> </u>	Physician: this certific ral director,	To Be	examiner?  1  Yes	Other	me <b>(Check only one)</b> The Residence	e 6 Other (Spec	ify)
on or	nding P tth. r: After t e funera	ation:	27. Manner of Death 1 Alatural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)  M 28b. Time of Injury (Month, Day, Year)	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION	after des after des Director d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ffice	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, n my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	Verithing Comp.	M	29b. Signature and title of certifier 29c. L	icense number	29d	. Date signed (Month	, Day, Year)
	CAD I		30. Name and additions of person who completed cause of death (Item 23a) (Type, Print)	00632	33	12/7/0	9
	+		580 C Northern Itue Hager	stown	MD	21743	1
	Sta Registra		31. Date filed (Month, Day, Year)  DFC, 7 2009  32. Registrar's Signatur				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Thomas B. Leatherbury 2009 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death. Examiner 50/1564M WIONMICO PENINSULA REGIONAL Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **№** M 2 🗆 F Director 218-40-6288 11-1-1942 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other traumatic event, Item Natical Evantines and Injury or other Evantines and Injury 10a. State 10h. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 □ No Director MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11374 Greenwood Road 21853 Funeral . A 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 1 ☐ Yes 2 ☐ No Specify. \$ ^{Sp}Black 3 Widowed 4 Divorced Year or Dates: 1970 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Contracting Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ |Bertha Christopher Archie L. Leatherbury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Oakley/Sister <u>1210 West Road, Salisbury, MD 21801</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MDVeteran's Cem | 12-7-2009 Hurlock, MD 22. Name and Address of Facility Bennie Smith 917 W. Isabella St Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cadse (Final Physician Physician 2 DIOMY OPATHU MANS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate once. Each of identifying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð After this certificate has been sign funeral director, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has autopsy certificate performed 1 □Yes 1 ☐ Yes 2 ☐ No 2 1NC 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation

P.O. Box 68760 Division of Vital Records, Physician: The After Hospital or Attending death. hours after death. filled in by

Maryland 21215-0036

Baltimore,

within 24 hours a ompletely

State

6 ☐ Could not be

determined

Desmarais

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3+353

100 E. Carroll St. Salisbury, MD. 21801

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 40323 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward R. Longstreet 2009 November 9:01am **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Dec. 8, 1 ★ M 2 □ F Months Days Hours ^{Ye}1958 144-60-8442 50 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll 1 Yes 2 No Marriottsville 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 7078 Melstone Valley Way 21104 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 V Yes 2 No1977

If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 er than "natural", or, the Medical Exan 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "i Elementary/Seconday (0-12) College (1-4 or 5+) Business Manager Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward D. Longstreet Rebecca Echinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Mrs. Renee Longstreet (Wife) 7078 Melstone Valley Way, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 12/4/2009 Owings Mills, MD 21. Signature of Funeral Service Licenses HAIGHPOPERATONER & CHAPEL, P.A. 40074 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final -ANOMA ⊕πysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy performe Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE this To the Hospital or Attending Phenitin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death Certificate: 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number **D006746** 29b. Signature 29d. Date signed (Month, Day, Year) 27/09 WJL on who completed cause of death (Item 23a) (Type, Print) 10 555 S. Center Street, Westminster, MD 21157 VARONG nd hut 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar Physic /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist DHMH 17 Rev 1/2001

	State of Ma					nd Mer	ntal Hyg	iene			
	1 - State Registrar Certificate of Death Reg. No. 2009 1032								40324		
ian cal	Decedent's Name (First, Middle, Last)  Molly Lou Hyder Ludwig  2. Date of Death Month Pay November 28, 2009							200°9°	3. Time of Death 3:00am M		
ner	4a. Facility Name (If not institution, give street and number)	-	4t	o. City, Town, or				4c. Cou	inty of Death		
	Carroll Hospice Dove Hou			Westmi					Carro.	<u> </u>	
	5. Social Security Number 217–28–1100 6. Sex 1 M 2 F 7. Ag	e (In yrs. last birt)		If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.		Min. De	Date of Birth (Month 1 ^{Day}	<b>19</b> 32	9. Birth	place (State or Foreign	
	Isual Residence of Decedent  Da. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
5	MD Carroll	100. Oity, 10WII		 Finksbur						1 □Yes 2 ☑No	
rect	10e. Street and Number			10f. Zip Code	· g		1	On Citizen	of What Cou		
Funeral Director	2160 Bollinger Mill Road	21048						USA			
nuel	11. Marital Status 12. Was Decedent Armed Forces?		13. Was	Decedent of His	spanic Orig	in? (Specify Puerto Rica	Yes or No-		Race - Amer Black, White,		
	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	1 ☐Yes 2 MNO Specify:					Specify: White				
Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent	t's Usual Occupa d of work done di NOT use retired)	ition uring most i	of working		16b. Kind o	f Business/Ir	ndustry	
E E	Elementary/Secondary (0-12) College (1-4or 5	)+)		^{NOT use retired)} Worker				State	of M	aryland	
ပ္သ	17. Father's Name (First, Middle, Last)		ase		18. Mother	's Name <i>(Fi</i>	rst, Middle, I			ai y i aiiu	
	John William Hyder						McA1is		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
은	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing A	ddress (Street a	nd Number	or Rural Ro	oute Number	. City or To	wn, State, Zi	ip Code)	
	Mr. Meredith E. Ludwig (Sp		_					-			
	20a. Method of Disposition	20b. Place of cemeters	Dispositio	on (Name of ory or other place	9)	Date		20c. Location	on - City or T	own, State	
	1 ☐ Burial A☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	All Cou		Crematio	ш ;	2/1/2			esvill	e, MD	
	21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784										
	23a. Part 1. Enter the disease, or complication 🔰 at caused shock, or heart failure. List only one cause on each li	the death. Do n								Approximate Interval Between	
	Immediate Cause (Final disease or condition	SMALL CELL CARCINOMA OF I'M								Onset and Death	
	resulting in death)  Due to (or as a consequence of):									LIN SILVEY	
je j	Sequentially list conditions, if any, leading to himselfate.	a consequence offic									
i E	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
EX:		a consequence of):									
edical Examiner	d										
an/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  23d. Date of d  Aporth  Aporth										
Physician/M	in the past 12 months?  1 □Yes 2 No 4 □ Pregnant a 9 □ Unknown							Month Day Year			
								the cause of death?			
edk						_	1 🗆 Ye	s 2 N	o 3□ Pro	bably 4 ☐ Unknown	
Completed by	autopsy prior									opsy findings available ompletion of cause of	
						]	perform 1 🗆 Yes	ned? 2 DaNo	death? 1 🗆 Yes	2 🗆 No	
Be	25. Was case referred to medical examiner?			Othe			heck only on		_	NO110 140134	
ı.T	27. Mann of Death 28a. Date of Inju	ry 28b. T	·	3 LI DOA			5 Reside			MyDove House	
tior	1		jury	28c. Injury Work' M 1 🗆 Y	?ີ ′es 2.∐N	1					
Medical Certification: To	3 Suicide 4 Homicide  Suicide 4 Homicide  Suicide  Suicide 4 Homicide  Suicide  Suicide 4 Homicide  Suicide  Suicide 4 Homicide  Suicide							umber or Rui	ral Route Number,		
al Ce	29a. Certifier 1 Certifying Physician: To the best	of my knowledge	death on	courred at the tim	ie, date ann	place, and	due to the r	ause(s) and	d manner as	stated.	
ledica	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								to the cause(s)		
								gned (Month			
										21157	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THOMAS K. CALLY III M 203 DIKON BOILDING WESTAWSTER MANULE										
ate	31. Date filed (Month, Day, Year) 32. Aegistr		par								
rar	OEC 0 1 2009 Com	n p.	you								

Amend Items 2 & 3 per Phy. 12/03/09 Carroll County, will State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No 2009 40325 Certificate of Death 1. Decedent's Name (First, Middle, Last) Now amber 28, 2009 11 Time 5 Death **Physician** 2009 Anna Marie Livesay November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1136 Fannie Dorsey Road Carroll Sykesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NC 8. Date of Birth (Month, Day, June 12 Social Security Number 7. Age (In yrs. last birthday) Year) 1933 **Funeral** Months Days 1 ☐ M 2 🖵 F 241-52-3610 76 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Madical Examinar in ust be inclined at MD Carrol1 Sykesville 1 Tyes 2X No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1136 Fannie Dorsey Road 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 27 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John T. Moore Lessie Owens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Larkin T. Livesay, Jr. (Spouse) 1136 Fannie Dorsey Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 12/3/2009 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signaty/je of Funeral Service Licenşee HAIGHT FUNERAL HOME & CHAPEL, P.A. MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** ardiac CL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 1- 27Pars Mona Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and I-tran physician ar s the burial-to Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) P.O. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has rector, page 2 s has autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jury (Brendon Herders. MP) Ste - Writmin 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 1 2009 Registrar

			For State Registrar	State of Maryla	-		of Health of Death		Re	g. No.20	09	403		
	Physici	an	1. Decedent's Name (First, Middle, La						<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of		
	/Medi	cal		Lavigne		Ah Cir. T	own or location	of Death	Novembe	er 30,		4:15	a ^M	
3	Examir	ner	4a. Facility Name (If not institution, given Montgomery Hos		156		own, or Location Rockville				or Death n tgome	e <b>r</b> v		
	Euroval		5. Social Security Number 6. S			If Under 1	Year If Under	24 Hrs.	8. Date of Birth			lace (State o	or Foreign	
и	Funeral Director				93 Yrs.	Months	Days Hours	Min.	(Month, Day, July 7.			York		
			Usual Residence of Decedent											
	urylan show d at	_	10a. State 10b. County		ity, Town or Lo					10d. Inside C				
	ne Ma Ba-f s ptiffer	ecto		ntgomery	Silver								2,1110	
	vith the	Funeral Director	10e. Street and Number			10f. Zip (			10	g. Citizen of	What Coun	try?		
	sath v	eral	15101 Interlact	nen Drive, #50			906	rigin? (Sne	cify Yes or No-	USA 14 Ba	ce - Americ	an Indian		
	ter d	표	11. Marital Status  1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, speci	nt of Hispanic Or ly Cuban, Mexica	n, Puerto F	Rican, etc.)		ck, White, e			
98	urs af		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	SNo Specify	:		Specif	y: Whit	te		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Modical Examiner must be notified at	Completed by	15. Decedent's E		16a. Dece	dent's Usual	Occupation	et of workin	1	6b. Kind of B	usiness/Ind	dustry		
215	thin 7 ie. an "r	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	done during mos retired)	St OF WORKE	ig					
7	ed wii ygien ier th	Co		4 .	Tea	cher					acatio	on		
Maryland	tal Hygie d other event, tt	Be	17. Father's Name (First, Middle, Last						(First, Middle, M	aiden Surnar	ne)			
<u>Y</u> a	ould I Men narke	မ	Edward W. Sulli					na Ba						
Jar	2 sh h and rism raum		19a. Informant's Name/Relationship ( Merlin James Lav		19b. Maili	ng Address ( N 1 Trat	Street and Numb erlacher	peror <i>Rur</i> a n Dri	I Route Number,	City or Town	, State, Zip	Code) 20	906 MD	
e,	es 1 and 2 should be filed vol Health and Mental Hygie fitem 27 is marked other ir other traumatic event, it		20a. Method of Disposition							Oc. Location				
Baltimore,	ages nt of nt of serious		1 Burial 2 ☐ Cremation 3 ☐	Themoval from State   Ar	Place of Dispo cemetery, crei	matory or oth n Nati	onal	Dec.		rling	,		ia	
ᄩ	permit. Pages 1 Department of I Important: If ite any Injury or of		4 Donation 5 Other (Special	y)	Cemet	ery	<u>i</u>		1				Ι. α	
Ba	permi Depa Impo any Ir		21. Signature of Funeral Service Lice	Leve-	-		Address of Facili						D 000	
			23a. Part 1. Enter the disease, or on	plications that caused the dea	th. Do not en		Iniversi				r spr	Approximat Interval Bet		
			23a. Part 1. Enter the disease, or our shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					, ,			Interval Bet Onset and I	ween Death	
	Physician /Medical		disease or condition resulting in death)	a. Debility  Due to (or as a conse	guence of):									
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	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Non-Hodgkin	s Lymp	homa		•						
o,	an an rial-tr	EX	resulting in death) Last	Due to (or as a conse	quence of):									
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89	ng ph	Med	IF FEMALE:	-						1				
Вох	eath certific attending p for use as f	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		☐ Ectopic pr	egnancy				ate of delive		Year	
O. E	e dea the at	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5[	Other (spe	ecify)				Ontil	Day	rour	
<u>0</u>	w requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying ca	use diven in Part	L	23e. Did toh	acco use con	tribute to th	ne cause of o	death?	
Š,	res the signer of the d	ğ	Hypertension	contributing to death but not re	suiting in the d	ingeriying ca	use given iirr are			s 2 □ No				
5	requ	Completed	7 E											
Records,	elaw hast e2s	du							24a. Was an autopsy	/	Were auto prior to cor death?	psy findings mpletion of a	available ause of	
8	Iclan: The I certificate ha ector, page			r					perform 1 □ Yes 2	No	1 ☐ Yes	2□No		
of Vital	or Attending Physician: The law requires that the death certificate be executed sifer death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Be	25. Was case referred to medical examiner?	Hospital:	7		Other	-	(Check only one					
o	Phys rthis ral dii	L	1 ☐ Yes 2 🖺 No  27. Manner of Death	1 Inpatient 2	ER/Outpatie		4 11		me 5 Reside			y) Kosp	Dice	
o	ding h. Afte fune	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	Injury	м	lc. Injury at Work? 1 □ Yes 2 □		Edd. Boodilbo ilo	ir injury occur				
Si	Atten deat ctor: y the	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At	nome, farm, st	reet, factory,			28f. Location (Str	eet and Num	ber or Rura	il Route Nun	nber,	
Division	al or after after Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	uty)	,			City or Town	State)				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying P	hysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred anvestigation,	at the time, date a in my opinion, de	and place, eath occurr	and due to the ca	ause(s) and nate and place	nanner as s , and due to	stated. the cause(s	s)	
	o the vithin of the complex co	Me	29b. Signature and title of certifier		2)		License number			d. Date signe				
	_		J. Koule	tcheu, n	W	D	63741	8	No	vembei	c 30,	2009		
	10		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type.	Print)								
			Jocelyne Kouatch			,	ive, #10	00, R	ockville	, MD 2	20850			
	Sta	ate	31. Date filed (Month, Day, Year)		nature 1	a Kel								

Alexander M. Murrell 09-09173

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 40327

State of Maryland / Department of Health and Mental Hygiene

**UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ November 25, 2009 1241 hrs **Medical Examiner** MONROE MURRELL ALEXANDER c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2445 Edmondson Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Director Alabama Nov. 12, 1945 1X M 2 64 228-62-4206 Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10b. County 1 X Yes 2 No s 23a or 28a-f show notified at once. · 28a-f show Baltimore Baltimore the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21223 2445 Edmondson Avenue 14. Race - American Indian, Black, with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1969 11. Marital Status pe If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death v 1 Never Married 2 Married must 1X Yes No to pumit. Pages I and 2 should be filed within 72 hours after I Devartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o in jury or other traumatic event, the Medical Examiner in Yes 2 X No specify: Black f Yes, Give Year 1975 4 X Divorced Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Hospital Chef 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cornelia Mae Holley Charles Monroe Murrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1653 Briar Bend Court, Stone Mountain, GA 30088 Shannon Murrell Hall, Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dec. 7,2009 | Triangle, VA Ouantico Nat. Cem. 4 Donation 5 Other Specify: 22. Name and Address of Facility Ames Funeral Home, Inc. 21. Signature of Funeral Service Licensee
Bernard O. Ames Be Hard CC0 208 8914 Quarry Road, Manassas, VA Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Death Medical a. Blunt Force Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical **AMENDED** UNPENDED the attending physician ed for use as the burial -Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes 1 ✓ Yes 2 No 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene examiner? DOA ER/Outpatient 3 Inpatient 2 this 1 V Yes 2 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Certification: Subject beaten FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Yes 2 ✔ No Division Natural 5 Pending Nov 25, 2009 1241 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 2445 Edmondson Avenue, Baltimore , MD Suicide (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 26, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mattingly 12 Elsie Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Feb 1, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 215-90-3232 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland **Funeral Director** 1 ☐Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 38 Virginia Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 KNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 X Widowed 4 Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Sathoff Helen (Fitzpatrick) Sathoff ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Virginia Avenue Cumberland MD 21502 Linda Mattingly daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/11/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ovona /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): HospItal or Attending Physician: The law requires that the death certificate be executed cate has been signed by the aftending physician and page 2 should be detached for use as the burial-trans P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 **N**0 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1. Datural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 1) 0033200

State Registrar 425 KENT AVENUE CUMBERLAND, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUPTAMD.

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3, 2009 Day Month **Physician** 1900AM December MILTON E. MURRELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Dorchesta ambridge General Dorchester 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthdav) **Funeral** 1 M 2 □ F Months Days Hours Min. Director 220-12-0995 9/17/1925 **MARYLAND** Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND DORCHESTER CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 1109 HOLLAND AVE 21613 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 

Yes 2 

No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☑ Married is marked other than "natural", or 1 ☐ Yes 2 ☑ No Specify. þ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced WHITE 1943 - 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REVENUE ADMINISTRATOR STATE COMPTROLLER 9 permit. Pages 1 and 2 should be fileo Department of Health and Mental Hyok Important: If item 27 is marked any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ **GRANVILLE MURRELL RENA JONES** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUE F. MURRELL/WIFE 1109 HOLLAND AVE, CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OLD TRINITY CHURCH CEMETERY 12/7/2009 CHURCH CREEK, MD 21. Signature of Funeral 22. Name and Address of Facility 1000 CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastro 12 tel trial Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Revol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last physician a the burial-1 Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy performed' certificate 2 L N 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 2 | 2 | 2 | 2 | 2 | 3 | 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner Death 28h. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. ours after death.
neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THANWY 503 CAMBRIDGE NOMAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

the Hospital or Attending Physician: within 24 hours after To the Funeral Direc

> 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Sputhall, MD 2. Registrar's Signature

29b. Signature and title of certifie:

and manner stated

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

December 8, 2009

**OCME** 

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Yea 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 8. Date of Birth (Month, Day, Year) 01/15/1953 9. Birthplace (State or Foreign rs, last birthday WV Country) Months Days Hours Min. 1 □ M 2 🕱 F 56 234-82-9419 Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 1√ Yes 2 No Tucker Davis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 William Avenue 26260 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∏Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Robert Golightly Marjorie Frances Sluger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 162 Davis, Doug Martin/Husband WV 26260 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Calvary 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2009 Thomas, WV 21. Signature of Funeral Service Licensee Hinkle Funeral Home, POBox 186 Davis, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month a. Widely disease or condition resulting in death) metastat Due to (or as aconsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No T Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Cath

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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Director

Funeral

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23a

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jes 1 and 2 s t of Health an If item 27 is

Pages

Department of Heal Important: If item 2 any injury or other

72 hours after

Saltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Examiner Physician/Medical

burial-transi and physician the as attending nse s ģ the þ cate has been signed page 2 should be det

law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

à Completed Be Certification: To

Medical

Natural
Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signal re and title of certifier

5 | Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d

shway oakland, ud 215 32. Registrar's State Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Paul Mossessian 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician. Month Day November 30, 2009 0248 hrs Medical Examiner Paul Mossessian 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Muncaster Mill Road and Avery Road Derwood If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 5. Social Security Number 7. Age (In vrs. last birthday) MD Months Days Hours Director 219-04-7464 26 May 13, Country 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County Yes 2 X No 28a-f show Maryland Montgomery Derwood narked other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at once. timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5901 Willow Knoll Drive 20855 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2 X No Yes Specify: White Yes 2 No specify: f Yes. Give Yea Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Complet marked other than 12 Electrician Electrical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Garabet Mossessian Elize G. Aghkekian Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tant: If item 27 is m 5901 Willow Knoll Drive, Derwood, MD 20855 Elize G. Mossessian/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) X Burial 2 Cremation 3 Dec. Removal from State Gate of Heaven Cemetery 2009 portant: Silver Spring, MD Donation 5 Other Specify: 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Servi Licensee Spring, MD 20901 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I, Enter the disease, of Physician Between Onset and failure. List only one caus /Medical Death a Multiple Injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown for g Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of performed? death? page ✔ Yes 2 1 V Yes certificate 25. Was case referred to medica 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Hospital: 1 Other 4 Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA Residence 6 V Other: Scene this 1 ✔ Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject driver of motorcycle in collision with Nov 30, 2009 0240 hrs Natura Yes 2 V No Pending death Director: filled in by the vehicle 2 🗸 Accident Investigation n 24 hours after de Funeral Direc 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)
Muncaster Mill Road and Avery Road, Derwood, MD determined (Specify) Roadway Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal within 2 To the I 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. November 30, 2009 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year DEC 03 Registrar's Signa State

Registra

			State of Maryland / Department   State of Maryland / Department   State   Stat	artment of Health and N rtificate of Death												
			Registrar  1. Decedent's Name (First, Middle, Last)	- Inodic or Bodin	Reg. N	2009	3. Time of Death									
	Physicia /Medic		Thomas Joseph McDermitt			01. 2009	9:00 am									
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death										
, mark			16909 Norbrook Drive	Olney		Montg										
	Funeral Director		5. Social Security Number  235-30-6492  6. Sex 1 🖾 M 2 🗆 F  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 01, 1	ar) Coun	lace (State or Foreign try) Virginia									
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation		1	0d. Inside City Limits									
	Maryla f sho	tor	Maryland Montgomery	Olney			1 □Yes 2 🛣 No									
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Coun	itry?									
	th with		16909 Norbrook Drive	20832		u.s.	Α.									
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e										
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Mudical Eventinar must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1943 — If Yes, Give Year or Dates: 1946	1 ∐Yes 2 120 No <i>Specify</i> :		Specify:	Caucasian									
5-0	72 hc	etec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring 16b.	Kind of Business/Inc										
121	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Police Officer		lice Depar	tmont									
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ylar	ould be Menta arked atic ev	To B	Thomas McDermitt		Regina M	lartin										
Nar	12 sho h and 7 is m traum	0.5		ng Address (Street and Number or Ru												
e,	1 and Healt em 27			Norbrook Drive,		LOCATION - City or TO										
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altimore,	mit. F partm sortar / injur	H	21 Signatura di Euparal Servitra Licenzas	2. Name and Address of Facility High	es-Rinald	i Funeral	Home. Inc.									
<u>~</u>	e a La	V H	Junyth. Join 10000 11	800 New Hampshire	. Ave., Sil	lver Sprin	g, MD 20904									
		,	23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximat Interval Bet Onset and I													
	Physician /Medical		disease or condition resulting in death)  a. Chrome Obstruct	tive Pulmonary Di	sease		Years									
and for	Examiner		Due to (or as a consequence of):													
	p #	iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
6	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):													
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Вох	ath ce ttendii or use	an/N		☐ Ectopic pregnancy		23d. Date of delive	ery Day Year									
o.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	1   Yes 2   No 4   Pregnant at time of death 5   9   Unknown	Other (specify)		Worth	Day Tour									
ď.	res that signed by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?									
ords	w requires been sig should be	ed p			1 🌠 Yes	2 No 3 Prob	oably 4 ☐ Unknown									
of Vital Records,	law re nas be	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of									
alF	ysician: The lis certificate hadirector, page				performed 1 □ Yes 2 🕏		2 □No									
ΖÏ	sicial s certi lirecto	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	th (Check only one)	0 TO# (0 )										
l of	g Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time o		ome 5 🕅 Residence 28d. Describe how in		y)									
sior	endin sath. or: Af he fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No												
Division	or Att after de Direct in by t	Certification: To	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura late)	ul Route Number,									
_	To the Hospital or Attending Physician: within 43 hours after death.  To the Funeral Director: After this certificat completely filled in by the funeral director, p		29a. Certifier  (Check only  Medical Examiner: On the best of my knowledge, deat    Certifying Physician: To the best of my knowledge, deat   Check only   Check	h occurred at the time, date and place	, and due to the cause	e(s) and manner as s	stated.									
	o the l	Medical	one) and manner stated.  29b. Signature and title of certifie	29c. License number												
	511		by Hu	D08381		December 2, 2009										
	211		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)												
			Benjamin Avrunin, MD, PA, 18111 Princ	e Philip Dr., #20	9, Olney,	Maryland	20832									
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0.3 2009  A Begistrar's Signature	Ked												

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 December Alberta Moore 1630  $P^M$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood at Williamsport Williamsport Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours (Month, Day, Year Maryland Director 219-20-2099 92 Feb. Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 16505 Virginia Ave. 21795 U.S.A. items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 10 Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clyde Ε. Clara Hose Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Arlene K. Mose / Daughter 229 Woodpoint Ave. Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Smithsburg Crematory 12/14/2009 Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Coensee any 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) cerebrovascular acciden Medical Due to (or as a consequence of): Examiner upertension uoars Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Kheumatica 24a. Was an page 2 autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 1 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D4745) ynthea Kuttrey. Vands, 150

State Registrar pice

Hos

Washington

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Sands Mp

		-	State	State of Marylan	-	rtment d tificate d				20	00	10005	
			Registra MFND#11perINF, 12  1. Decedent's Name (First, Middle, Last)	2-4-09, BMW, MbCo	Cer	illicate c	Deam		2. Date of Dear	leg. No.	117	40335	
	Physicia Medic	n/		arx					Month Novembe	Day	Year 09	3. Time of Death 9:52 а м	
 ممري	Examin		4a. Facility Name (if not institution, give stre 3118 Gracefield Road, T	•		-	n, or Location Spring	of Death		4c. Count	y of Death <b>Montg</b>	omery	
	Funeral Director		5. Social Security Number 6. Sex 187–05–5016 1 № 1	7. Age (In yrs. ia 91	as <i>t birthday)</i> Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	er 24 Hrs. Min.	8. Date of Birth	⁷ 13/18		olace (State or Foreign try) Ivania	
	now at	١	Usual Residence of Decedent  10a. State 10b. County	10c City	y, Town or Loc	ation					1	0d. Inside City Limits	
	larylan 3a-fsk iffied s	Director		gomery		Spring					l'	1 ☐ Yes 2 ♣ No	
	the M	I Dir	10e. Street and Number	3 3		10f. Zip Co	de			10g. Citizen of What Country?			
	h with 1s 23e nust l	Funeral	3118 Gracefield Road,	T-17		20	0904			USA			
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No If Yes, Give WWII Year or Dates.		Vas Decedent Yes, specify (	Cuban, Mexic	an, Puerto I	cify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, c /: <b>White</b>	′ .	
21215-0036	2 hour	Specify: V  Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  Thuman Resource Analyst  Specify: V  Give kind of work done during most of working life. DO NOT use retired)  Human Resource Analyst  Government								Business Inc	dustry		
77	vithin 7 iene. ir than the M	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	NOT use reta Human	Resourc	e Anal	yst	United Governm			
nd	filed v tal Hyg d othe event,		17. Father's Name (First, Middle, Last)				18. Mot		(First, Middle, I	Maiden Surnan	ne)		
Baltimore, Maryland	uld be d Ment marke natic	욘	Frank Marx  19a. Informant's Name/Relationship (Type,	Deint)	T				Theabold				
Σ	d 2 sho alth an 27 is rrtraun		Janice Williams/Daughte	,					Route Number ver Sprin	•		Jode)	
ore,	of Hes		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Disportemetery, cren	sition (Name o	of		ate	20c. Location		own, State	
<u>H</u>	t. Page tment tant: I		4 Donation 5 Other (Specify)	movar nom state	e of Hea	even Cem	etery	Decem				,Maryland	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licensee	Cole	50	Name and A 00 Unive	ddress of Fac rsity Bl	s Fune	ral Home , Silver	Inc. Spring,	MD 209	20901	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
1	Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):										-	Onset and Death	
	Examiner	L	Sequentially list conditions, b.										
0	sit od	Examiner	if any, leading to immediate cause (Disease or iinjury	Due to (or as a consequ	uence of):						- 3		
0	xecute n and al-tran	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):								
09	ate be executed physician and the burial-transit	dical	d.										
3876	ertificat ding ph e as th		IF FEMALE:	c. If yes, outcome of pregna	ancı.								
P.O. Box 687	ss that the death certific igned by the attending I be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of	aldeath 3	Ectopic preg Other (speci	gnancy fy)				ate of delive onth	ery Day Year	
О.	t the d by the	Phys	9 🗌 Unknown	g ∐ Unknown			aa aiyaa in Do						
ري. ح.	res tha signed	d by	Part II. Other significant conditions control	ibuting to death but not res	suiting in the u	ngeriying caus	se given in Pa	rt I.				ne cause of death?	
ord	v requires been sig should b	lete							24a. Was a		. Were auto	psy findings available	
Rec	The lav ate has page 2	Som	-						autop perfor 1  Yes	med?	prior to co death? 1 \( \subseteq \text{Yes}	mpletion of cause of	
ta	ician: sertifica ector, I	Be	25. Was case referred to medical examiner?	spital:		2	26. Place of De	eath (Check					
ζ	Physi rthis o eral din	e: To	1 Yes 2 XNo	1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of		Other: 4  Injury at		me 5 🔼 Resid			)	
ouo	ending tath. rr: Afte	ficat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		work? 1 🗆 Yes 2			,,			
Division of Vital Records,	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		et, factory, of	ffice		28f. Location (S City or Tow		ber or Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  Within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine)	an: To the best of my know : On the basis of examinatio	ledge, death on and/or invest	occured at the	time, date an	id place, an	d due to the cau	use(s) and man	ner as state	ed. use(s) and manner stated.	
	o the hithin 2.	Me		Practioner: To the best of m		death occurred		ate and plac	e, and due to the		nanner as st	ated.	
	1701		▶ White	1			D24035			November			
			30. Name and address of person who com Eugenio Machado, MD	pleted cause of death (Iten			er Sprine	g, MD 2	20904	<u> </u>			
Ī	Sta Registr		31. Date filed (Month, Day, Year)  DEC 03 2009										

se Rosaly Mel		tate of many target and the	t of Health and Mental H		2009 40330
		Registrar	or Death	Reg. No.	
Physicia edical Exami		Decedent's Name (First, Middle,Last)  Jose Rosaly Melendez		2. Date of Death Month Day December 8, 2009	
1		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		ounty of Death ntgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 17. Age (In yrs. last birthday 18. Age (In yrs. last birthday	/) If Under 1 Year If Under 24Hrs Months Days Hours Min. Yrs.		(YYYY) 9. Birthplace (State or Foreign Country)E1 Sa1vad
, and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L		00,00,00	10d. Inside City Limits
yland -f show a	tor	Md Prince George Hyattsv	7ille	I 10 - Cilinan	1 X Yes 2 No of What Country?
ith the Maryland 23a or 28a-f show any notified at once.	Director	5429 Sargent Rd.	20782	-	ed States
r death w or items must be	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  X Yes 2 No specify: Sal	Rican, etc.)	Race - American Indian, Black, White, etc.  ecify: Hispanic
2 hours afte "natural",   Examiner	ted by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of variety most of working life. DO NOT use reti	vork done 16b. Kind	d of Business/Industry
0036 within 72 iene. er than "	ompleted		ngineer		lf Employed
be filed and the filed arked oth	Be C	17. Father's Name (First, Middle, Last) Ramon Melendez	Purifi	(First, Middle, Maiden Sur .cacion Umana	a
rre, MD 21215-0036 s. I and 2 should be filed within 77 s? Health and Mental Hygiene. If item 27 is marked other than per traumatic event, the Medical	^L		ailing Address (Street and Number or F 29 Sargent Rd. Hyat		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 X Burial 2 Cremation 3 Removal from State crematory of	sposition (Name of cemetery, or other place)		ation - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility JC	ohn T. Rhines	rict of Columbia Funeral Home
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	3005 12th. St. NE ter the mode of dying, such as cardiac of	Washington respiratory arrest, shock,	or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Sudden unexplained  Due to (or as a consequence of):	death in epilepsy		Death
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted I msit	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.			
D, the executed sician and ourial - trans	edical	X UNPENDED AMENDED 23a,27,permE,	g900 2/22/10 TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregna		onth Day Year
P.O. BO. that the deat need by the at detached for		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		e contribute to the cause of death?
ds, P.C equires that een signed l	eted by			24a. Was an	o 3 Probably 4 ✓ Unknown  24b. Were autopsy findings available
Vital Records, Fysician: The law requires this certificate has been sign director, page 2 should be	Completed			autopsy performed? 1 ✓ Yes 2 No	prior to completion of cause of death?  1  Yes 2 No
cian:	Be	25. Was case referred to medical examiner?	26.Place of Death (Check		o 🗆 ou
n of Vi ing Phys After this funeral di	n: To	1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time	e of Injury 28c. Injury at Work?	g Home 5 Residence	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death.  seral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detact	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm,	1 Yes 2 No street, factory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		4 Homicide determined (Specify)  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigations.	occurred at the time, date and place, and	I due to the cause(s) and m	nanner as stated.
	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
4-Pend	_	Thedre M. King Jr., und.		PRE	mber 10, 2009
			nn Street, Baltimore, MD 2120	1	
Si Regis	tate trar		wed .		

		-	For	State of N	Maryland		artment of			lental Hyg	iene	00	10007			
			Registrar	( ant)	<del></del> .	Cer	tificate of	Death	7		eg. No. 🚄 U	09	40331			
	Physicia	n/	Decedent's Name (First, Middle,							<ol><li>Date of Deat Month</li></ol>	Day	Year	3. Time of Death			
	Medic		REX  4a. Facility Name (if not institution, g	RAPHAEL		ARTIN	0: 7	1	- (5 "	DECEMBI			11:07A M			
	Examin	er					4b. City, Town,		n of Death		4c. County					
	Funeral		FREDERICK MI  5. Social Security Number		Age (In yrs. la:	st birthday)	FREDER		er 24 Hrs.	8. Date of Birth	FREDI		lace (State or Foreign			
	Director		232-42-4370	X□M2□F	89	Yrs.	Months Days			April Day			Virginia			
	Α.	ļ	Usual Residence of Decedent										8			
	/land f sho ed at	햦	10a. State 10b. County  Maryland Frede	wi ole		, Town or Loc ederic						1	0d. Inside City Limits			
	Mar 28a- otifie	ie		LICK	LIE	deric							1 X Yes 2 □ No			
	th the	al	10e. Street and Number 301 Grove Bl	d			10f. Zip Code 21701				10g. Citizen of V U.S.A		try?			
	th wir	Funeral Director				Lion		I Par	0 (0	<u> </u>						
	r dea		<ol> <li>Marital Status</li> <li>Dever Married 2          Married</li></ol>	12. Was Deceder Armed Forces Ed Yes 2	5?		Vas Decedent of f Yes, specify Cub					e - Americ k, White, e				
ဗ္ဗ	al", c	Completed by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	TATAT TIT	[   1	☐ Yes 2 🕅 N	o Speci	ify:		Specify:	Whi	te			
ğ	hours natur lical	lete	15. Decedent	's Education			lent's Usual Occu				16b. Kind of Bu	usiness Inc	lustry			
걾	in 72 e. ian "i Med		(Specify only highes Elementary/Seconday (0-12)	<del></del>	or 5+)	life. Do	kind of work done  O NOT use retired	d)	ost of worki	ng						
7	within gient the ref. The			College (1-4 o +5		Medic	cal Doct	or			Health	Lare	5			
nd	tal Hy d oth	To Be	17. Father's Name (First, Middle, La	•						e (First, Middle, N e M. Tee		e)				
<u>Ş</u>	Men arke	٦	Harry J. Mar					<u> </u>	ATTIIITE	e M. Tee	ets		<u> </u>			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Spacetair: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi Mrs. Ann Y. Mar				ig Address (Stree Grove Bl						code)			
e,	and 2 Health em 2 ther 1		20a. Method of Disposition	till, wile	20h BI	L	sition (Name of	, va • 9					01-1-			
jo	nt of nt of ror or		XX Burial 2 Cremation		to Ce	metery, cren	natory or other pla ivet Cem	ace)	!		20c. Location -	•	·			
를	artme artme ortan injun		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Line	-	Moc				1				· ·			
Ba	Depi Impo any		21. Signal volve interacter vice in		M0025	55   "	106 Eas	and 1	dastoi urch S	a PA Fu St. Fre	meral E derick.	ome MD	21701			
			M00255 106 East Church St., Frederick, MD 21701  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													
	ำเงอเตเลน		shock, or heart failure. List only one cal se on each line.  Interval Between													
	Medical		disease or condition resulting in death)													
	Examiner		Company tight link and diking	ь												
	_	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequ	ence of):										
<b>L</b>	cuted ind transi	хаш	Cause (Disease or linjury that initiated events	c												
8	e exe	al E	resulting in death) Last	Due to (or a	as a consequ	ence of):										
9	ate be executed ohysician and the burial-transit			d						0 • 11						
687	ath certifica attending p	/We	IF FEMALE:	23c. If yes, outcon	ne of pregnar	ncv										
X	ath ce	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birt	h 2 🗌 Feta	death 3	Ectopic pregna Other (specify)	ncy			23d. Da	te of delive nth	ery Day Year			
P.O. Box 687	es that the dea signed by the a be detached f	Physician/Me	1 ∐ Yes 2 ∐ No 9 □ Unknown	9 🗆 Unknow		can o L	d Ottor (opeciny)									
<u>0</u>	that the	y PI	Part II. Other significant condition	- 4	h but not resu	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did tol	oacco use contr	ibute to th	e cause of death?			
s,	n sign	q pe	arterios	chrotic	cur	9100	as whe	ndi	Ma	و 1□Y	es 2 No	3 🗆 Prob	pably 4 🗆 Unknown			
orc	v require s been si should b	olete								24a. Was a	n 24b.\	Vere autor	sy findings available			
Sec.	he law te has age 2 s	Completed by								autops	med?_   0	death?	npletion of cause of			
a F	an: T tifica tor, p		25. Was case referred to medical				26.	Place of D	eath (Check		2 No	1 ☐ Yes	Z LI NO			
Ζİ	nysici iis cei direc	TO E	examiner? 1 ☐ Yes 2.Æ(No	Hospital:	atient 2	ER/Outpatier	nt 3 🗆 DOA Of	ther:	Nursing Ho	me 5 🗆 Reside	ence 6 🗍 Othe	er (Specify)				
of	ng Pt fter th ineral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of in (Month, i	njury Day, Year)	28b. Time of injury			$\overline{}$	28d. Describe ho						
ion	tendi leath. or: A the fu	ifice	2 Accident Investigation of Could n	ation ot be			M 1[	Yes 2	□No							
Division of Vital Records,	or Att	Certificate:	4 Homicide determin	28e. Place of	Injury - At hor etc. (Specify)		eet, factory, office	•		28f. Location (St City or Town		er or Rural	Route Number,			
	spital ours a leral C		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	adae death (	occured at the tim	ne date an	nd place, an	d due to the cau	se/s) and mann	ar ac ctata	d			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	caminer: On the basis of Nurse Practioner: To t	of examination	and/or invest	tigation, in my opi	nion, death	occurred at	the time, date an	d place, and due	e to the cau	se(s) and manner stated.			
	To th withir To th comp	-	29b. Signature and title of certifier					se numbe			29d. Date signed					
			Duritin	Lorre			Do	96	89		12	18/	09			
	10		30. Name and address of person w	the completed cause of	f death (Item	23a) (Type, F	Print)	Face	dowi cl	, MD 21	701		-			
سين	12		A. Austin Pearr	71			oureer,	TIE	GELIC	رے س <i>ت</i> وی		-				
	Stat Registra		DEC 17 2009	Server 32. Hegis	strar's Signat	parts	0									

09-09292	
Harvey Maddox	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hydiene

arvey waddox		1- For State Registrar	or Maryland / De	Certificate of E			200 Reg. No.	9 4033
Physici ledical Exami		Decedent's Name (First, Middle, Last	-/		ı i	2. Date of De		3. Time of Death
neulcai Laaiii	IIICI	4a. Facility Name (if not institution, giv	Matthe		addox City, Town, or Location		er 30, 2009 4c. County of Death	0712 hrs
		McCready Memorial Hosp		1	Crisfield		Somerset	
Funeral		5. Social Security Number 6. So	ex 7. Age (In y				Foreig	
Director		220-66-4320	(M 2 F 53	Yrs.	Months Days Hou	rs Min.		untry) MD.
tuy		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Location			•	10d. Inside City Limits
/aryland 28a-f show any 1 at once.	ř	Maryland Samer		risfield				1 Yes 2 No
daryla 28a-f	Director	Maryland Somer	70.		0f. Zip Code		10g. Citizen of What Cour	ntry?
h the l		154 Somers	Cove		21817		U.S.A.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	If Yes,	Decedent of Hispanic Or specify Cuban, Mexica	rigin? ( Specify Yes or N n, Puerto Rican, etc.)	lo- 14. Race - Ameri White, etc.	can Indian, Black,
fter de			1 Yes 2 N		es 2 <b>X</b> No specifi	v:	Specify: RV	ack
ours a	d by	15. Decedent's Education (Specify or	or Dates:	i) 16a. Decedent's	Usual Occupation (Give	e kind of work done	16b. Kind of Business/I	
36 in 72 h han "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		of working life. DO NO	r use retired)	0 ().	
d with	Com	7.th grade  17. Father's Name (First, Middle, Last		Lab	ocer 18.Mothe	er's Name (First, Middle	Maiden Surname)	Construction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Wesley W. M				Torence 1		
D 21 should and Me is ma	ြ	19a. Informant's Name/Relationship (T	ype, Print )	19b. Mailing A	ddress (Street and Nu	mber or Rural Route Nu	umber, City or Town, State	
and 2: ealth 2 ten 27		Johnny Maddo 20a. Method of Disposition	K-Brother	312 Ob. Place of Disposition	Pine >+ ,	Hp+, 28	20c. Location - City or	mcl, 2/8/7
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. I ant: If item 27 is marked other than 'or other traumatic event, the Medical		1 Burial 2 K Cremation 3	Domeyal from Ctata	crematory or other	place)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		4 Donation 5 Other Specify 21. Signature of Funeral Service Licer	see	alisbury (	e and Address of Facil	1315109	Salisbury E. Ward F	, mar
<u> </u>		Arthy & - W	und fr	1 30	USI TEIME	oden, Ave,	Princes Hare	mel 71853
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the de ach line.	eath. Do not enter the i	mode of dying, such as	cardiac or respiratory a	rrest, shock, or heart	Between Onset and
-xaminer			Hypertensive Cardio Due to (or as a consequence					Death
	.	Sequentially list conditions, b.	230 (0. 00 0 00.00400110					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause  (Disease or injury that initiated c.	Due to (or as a consequence	ce of):				
ed sit	xan		Due to (or as a consequenc	ce of):				
760, icate be executed physician and the burial - transit		d. UNPENDED	AMENDED					
60, ate be hysicia	Medical	IF FEMALE:	23c. If yes, outcome of p	regnancy			23d. Date of delivery	,
Sox 687 leath certific e attending p	jan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time o	2 Fetal	death 3 Ector	oic pregnancy		Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown		of death 5 Other	(Specify)			
P.O. s that the gned by t	by Pt	Part II. Other significant conditions	contributing to death but n	ot resulting in the und	erlying cause given in F		tobacco use contribute to	
S, P.C luires that signed!	ed b	Cirrhosis of the liver					es 2 V No 3 Prot	,
Records, The law require	Completed		<del></del>					topsy findings available completion of cause of
tal Rection: The certificate ector, page	5					1 ✔ Yes		es 2 No
Vital ysician his certi director	Be	25. Was case referred to medical examiner?	lospital:	✓ ER/Outpatient 3		Nursing Home 5	Residence 6 Other	
of \\ ng Phy \text{Vfter th} \text{ineral c}	٩	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injur			how injury occurred	
ion trendin leath.	atio	1 V Natural 5 Pending 2 Accident Investigati			1 Yes 2	No		
Division of Vital tal or Attending Physician: rs after death. al Director: After this certified in by the funeral director.	Certification:	3 Suicide 6 Could not	be 28e. Place of Injury - A	At home, farm, street, f	actory, office building,	etc. 28f. Location or Town,	(Street and Number or Ru State)	ral Route Number, City
lospitz Tospitz Tunera		29a. Certifier	an: To the best of my know	ladge death occurred	at the time, date and n	Jaco, and due to the an	10.0(a) and manner on state	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of	Medical		On the basis of examination and manner stated.					
	M	29b. Signature and title of certifier	and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t		29c. License numbe	r	29d. Date signed (Mo.	nth, Day, Year)
87		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	- 1 m		O.C.M.E.		December 1, 200	09
0		30. Name and address of person who Donna M. Vincenti, MD	completed cause of death (I Assistant Medical Ex	,	enn Street, Baltin	nore. MD 21201		
St	ate	31. Date filed (Month, Day Year)		nature		-,		
Regist	rar	UEU - 3 1	CUUS Ceneur	1. De	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DAISY LAVERN MILLER DECEMBER 01, 2009 11:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number 8. Date of Birth (Month, Day, MAY 31, If Under 1 Year | If Under 24 Hrs. 6 Sex (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 🕶 F 74 215-40-1425 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **MARYLAND** HARFORD 1 XYes 2 No **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716A FOUNTAIN ROCK WAY 21040 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Specify: AFRICAN If Yes, Give Year or Dates 1 ☐ Yes 2X No 3 Widowed 4 Divorced AMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL PEAKER GERALDINE BEASLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIE MILLER / HUSBAND 1716A FOUNTAIN ROCK WAY, EDGEWOOD, MARYLAND 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State JOHN WESLEY UNITED METH 4 Donation 5 DOther (Specify) 12/7/09 ABINGDON, MARYLAND 21. Signature of Funeral Service Licenses Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 - Calconor - Jest 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con duence of): Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an

**Physician** /Medical Examiner Examiner death certificate be executed

Important: If It any Injury or o once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Maryland

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Director

Funeral

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requires that the

Physician:

or Attending

Completed by Physician/Medical

Be

Certification: To

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filled in by

within 24 hours a

To the Funeral C Hospital

3

IF FEMALE 23b. Was decedent pregnant in the past 12 plonths? 9 Unknown

1 Yes 2 No

27. Manner of D ath

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

autopsy performer 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 5 Pending investigation

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Denwa

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

1 ☐ Yes

30. Name and address of person who completed a se of death (Item 23a) (Type, Print)

DEC 0 3 2009

Mikityanskaya la 500 Upper Chesapeake Drive Bei Air, MD 31. Date filed (Month, Day,

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wheeler Sylvester Meadows Jr. 8:25 26, 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 5830 Bay Street Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 XM 2 □ F 229-38-5139 80 Director 04/03/1929 Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Salisbury Wicomico Maryland 10g. Citizen of What Country? 10e. Street and Number 5 21801 USA items 23a 5830 Bay Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Tyes 2 No Army If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 → No Specify. Specify: δ white 3 Widowed 4 Divorced Korea Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other treasures. construction worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wheeler Sylvester Meadows Sr. Lillie Mae Chewning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5830 Bay St., Salisbury, MD 21801 Betty Ann Meadows/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 11/30/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 aire of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) buro on do cring Grastatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) ned by the a P.0. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ficate has been signs, page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an The certificate l 1 ☐ Yes 2 No 1 □Yes 2 □No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tittee of certifier 29d. Date signed (Month, Day, Year) 29c. License number address of son who completed cause of death (Item 23a) (Type, Print) Sa STATIONNO Za 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 29, 2009 **Physician** s. Jeffrey McNeill 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbury Wicomico 30631 Foxchase Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 54 212-60-2305 **Director** 05/25/1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar in ust be neithed at 1 ☐ Yes 2 🗽 No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 30631 Foxchase Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) architect architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Foote Robert E. McNeill ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen McNeill/spouse 30631 Foxchase Dr., Salisbury, MD 21801 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/1/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Solvice Licen Phorna and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Admocarcinona of Broghagos **Physician** disease or condition resulting in death) 700-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause ( ) leads or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed burial-transi and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? yes 2 100 I□Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death.

Director: After d in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 0009 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Gran St., Folisbury, MD 21801 JUNES E. MARTIN NO 100

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Days

32. Registrar's Signature

Jeneur

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **28** Month **Physician** November 2009 <u>Ann Marie Mills</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner HARLES MEDICAL ENTER IVISTA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 1□M 2X F Months Days Director 577-52-5728 August 20. 1939Washington D.C Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, In. Medical Event. 1 □Yes 2X No Director Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2005 St. Thomas Dr. # 211 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Specify: White 3 ¼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th. Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Jennings Virginia Beach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Mills/ Son 911 Copley Ave., Waldorf, Maryland, 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Trinity Mem. Gardens | Dec. 4, 2009 Waldorf, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, Maryland 20601 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence on: burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, physician 8 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 □Yes 2 No o 9 Unknown σ. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 K No 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Please Type or Print in Black Indelible in Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

of Vital Division

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within 24 hours a Medical State Registrar

Certification: To

funeral

After

death. ours after death.

neral Director: A
filled in by the fu

31. Date filed (Month, Day

29b. Signature and title of certifier

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

dnas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abbas A. Onas MD Cenna Medical Center 7-C Post Office Rd Walderf Md 20602 32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:15 AM November 2009 Jeannette S. Medairy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 -Months Days Hours Min. (Month, Day, Year) Country)
Maryland 81 Director Feb. 215-26-1256 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7407 Willow Road 21702 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Completed 3 XWidowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item Z7 is marked other the any injury or other traumatic event, the once. Scottish Rite Temple Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ R. Victor Stanley Blanche Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Dertzbaugh - Daughter 5399 Beulah Drive, Ijamsville, Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Damascus Cemetery 11/30/09 Damascus, Maryland 4 Denation 5 Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home west 26401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician DEMENTIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or finjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical al or Attending Physician: The law requires that the death certificate be a safer death.

I Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTE NUION ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown DEPRESSION NEUROPATHY Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 4 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 021936 MD mekon

State

Registrar
DHMH 17 Rev 7/2009

THOMAS VOHOLON DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

65C

32. Registra s Signature

DONELSON

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Esther Rose Matney 2009 1:05 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood at Crumland Farms Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Pennsylvania Days Hours (Month, Day, une 24 Director 166-14-8779 87 June Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Frederick Md. Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Me iteal Examiner must be a Funeral 7401 Willow Road 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? X Yes 2 No 1945 Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 1946 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Owner - Operator Answering Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Edna Bardell Arnold Ε. Mensch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn M. Collins / Daughter 24005 Hawkins Creamery Ct., Gaithersburg, Md.20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Mt. Olivet Cemetery 11/28/09 Frederick, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen-Muriel H. Barber Funeral Home/ P.O.Box 5038 Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate nsat and Death SEPSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ship vetive Pulmonay Disease Examiner YEARS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 1 Yes 2 7 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check only or Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 0006222 November 25, 2009 lame and address of person who completed cause of death (Item 23a) (Type, Print)

PAYEEM BOLANUM, MO 196 TODLINE, FREDERICE, MD 21702 25H

Registrar

RAYEEM

31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended #20b perFH FCHD, KS Certificate of Death 11/30/09 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 548 AM MYERS EmmA JEAN November 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON COUNT HOSPITAL WASHINGTON HAGERSTOWN Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Hours (Month, Day, Year) - Z MD, 213-60 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** FREDERICR mo. FREDERICK 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21701 486 CARROLLOON UJA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1. Never Married 2 Married ☐ Yes 2 No Specify: BLACK 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Seconday (0-12) College (1-4 or 5+) NOSCAPING 10 74 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEROY ELLA DORSEY Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) POWELL HAGERSTOWN MO. AVALON AVE 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WeSmithsburg Crematowov. 24, 200 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee L. ROLLINS 22. Name and Address of Facility Rollis 10. FREDERICK MO 21701 'Hen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Enysician/ Cholansiocarcinone disease or condition ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate I 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 11.13.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

11110

32. Registrar's Signature

McCorneck

2009

Michael

NOV

31. Date filed (Month, Day, Year)

Hagerstown

# Baltimore, Maryland 21215-0036

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Ī	Physici /Medic		1. Decedent's Name (First, Midd Martha Katharin									2. Date of D Month Novemb		Ž3, 2	<del>ა                                    </del>	3. Time o	Death A M
	Examin		4a. Facility Name (If not institution Glade Valley Nu	-				Wa	1kers	Location ovill	e	1	40	C. County	of Death	:k	
	Funeral Director		5. Social Security Number 217–28–5297	6. Sex 1 ☐ M 2 🔀		(In yrs. la	nst birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E May 26	Day, Year	Year) 1933 9. Birthplace (St Country) Virgini			or Foreign
5-0036 72 hours after death with the Maryland	28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Fred  10e. Street and Number	lerick			Town or Lo		in Code				40-0				City Limits 2 ⊠ No
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J.36 rs after death	l", or items 2 vaminar mu	by Funeral	11. Marital Status  1 □ Never Married 2 Mar  3 □ Widowed 4 □ Divorced	12. Was Arme 1 □\ If Yes	Decedent End Forces? Yes 2 No. No. No. No. No. No. No. No. No. No.			Vas Dece fYes, spe 1 □Yes	edent of H ecify Cuba			pecify Yes or N o Rican, etc.)		14. Rac	e - Americk, White,	can Indian,	
21215-0036 d within 72 hours aft	is if any 2 should be med within 7.2 hours after death with the wadylan Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Evancher ryant to notified at	Completed		nt's Education st grade comple		)	16a. Dece (Give life. I	dent's Us kind of w DO NOT i	ual Occup ork done o use retired	ation during mos	t of wor	king	16b. I	Kind of Bu	usiness/In	dustry	
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat									City or To	wn, State	nd			
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	Sta Registr		30. Name and address of person  Hemen S  31. Date filed (Month, Pay, Year,	nah	cause of de		Thomas		J	ohn	Sen	n by	<u> </u>	Fr	ede	VICE	-1702 MD

Registrar DHMH 17 Rev 1/2001 09-08502 Patsy O. McClaine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

tsy O. McCla	ine		For State	State	or iviaryianu /		cate of l		u mom		Reg. N	No. 2(	109	4034
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 Department of Health and Mental Hygiene. Interpret than the control of the permitted other than interpret than the permitted other than the permitted other than the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permitted of the permi		1	21. Januature of F	uneral Stylice Lice	horse /							neral Ho		50
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Di spital	y filled	Cert	4 Homicid	determi	ned (Specify) sician: To the best of	f m knowlodg	o doath occ	urred at the tim	e date and	place, and du	ue to the caus	se(s) and manner	as stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	completely filled in by the funeral	Medical	29a. Certifier 1 (Check only one)	✓ Certifying Phys ✓ Medical Exami	ner:On the basis of e	examination an	d/or investig	ation, in my op	inion, death	occurred at t	he time, date	and place, and d	06 10 1110 00	
_	con	Mec	29 Signature a	and title of certifier	and manner state	ou			cense numb	er		29d. Date sign		Day, Year)
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_			30. Name and a		ho completed cause of sistant Medical E		^{23a)} 111 Per	n Street, B	altimore,	MD 2120	1			
	_    -	ate	31. Date filed (A	Month, Day, Year)	32. Regis	strar's Signatu		W.						
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OCME

09-09703 Tyrone Miner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 40348 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 2129 hrs December 13, 2009 Medical Examiner Tyrone Leonard Miner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Washington County Hospital Hagerstown 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Mary Land Months Days Nov. 8,1954 218-62-8358 Director 1 X M 2 F 55 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Marvland|Washington County Hagerstown or 28a-f show notified at once. death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21740 U.S.A. 115 Jonathan St. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
X Yes 2 1 Never Married 2 Married Specify: Black Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after or the of Health and Mental Hygiene. 4 X Divorced If Yes, Give Year Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) dother than " the Medical Baltimore, MD 21215-0036 Laborer Restaurant 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria Louise Miner Harris Be Uzel McNeal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Douglas Miner-brother 61 Elizabeth St. Hagerstown, MD 21/40 If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 12-16-2009 Smithsburg, Maryland Donation 5 Other Specify 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North <u>Hagerstown</u> Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure, List only one cause on each line. Death /Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED physician a AMENDED 23a,27,per ME g898 12/28/09 TT The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown è Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed? 1 🗸 Yes No Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other: Hospital: Residence 6 Other Inpatient 2 CER/Outpatient 3 DOA Nursing Home 5 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: 1 X Natural Yes 2 No Pending Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 14, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra

**ORIGINAL** 

32. Registrar's Signatur

31. Date filed (Month, Day, Year)

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, ·			William Hill M 5. Social Security Number		7 A (1	franklighten	1	aston r 1 Year	l If Under 2	04 Hre I	0 0-1(0)	41.	Talbot		
	neral ector		212–28–5157	1 M 2 X F	7. Age <i>(In yrs.</i> <b>94</b>	. <i>iast birtnday)</i> Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D 10/25/	ay, Year)			
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U Z I Z I S-0050  Ified within 72 hours after death with the Maryland Hygene, Hygene, Hhar "Instirral", or items 23a or 28a,f show	L L	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	J.S. 13.				gin? (Spec	cify Yes or No	USA 4. Race - An	nerican In	idian,	
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Should be and Mental	atice	To	Raymond Wrigh	ıt Lee						Rose	Rieck	ζ			
2 sho	raum		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rural	Route Numb	er, City or	Town, State	, Zip Cod	e)
l and lealth	ther t		Leigh Melton,	Granddaugl									ston,		
Daillinore, Interfylding ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Immortant: If then 27 is marked other than "natural" or items 23a or 28a4 show	or o		20a. Method of Disposition 1 Burial 2 X Cremation		nate	Place of Dispo cemetery, crei			1 i	Da			ation - City o		
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deat	th. Do not en	O So ter the mo	u <b>th</b> de of dyin	darris ig, such as	cardiac of	respiratory	rrest, as1	ton, M		Toximate rvai Between
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/Med			resulting in death)	Due to (c	or as a consec	quence of):	•—	N		<u> </u>	00	Λ	*		_
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ath ce	or use	Physician/Medical	23b. Was decedent pregnant in the past 12 menths?		irth 2 ☐ Feta	al death 3	Ectopic		y			25	3d. Date of d	elivery Day	Year
he de	shed f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ∐ Pregna 9 ☐ Unkno	ant at time of	death 5	☐Other (s	pecify)					WOTH	Day	Teal
that t	detac		Part II. Other significant condition	ns contributing to de	ath jolut noot res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco us	e contribute	to the car	use of death?
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hysic this o	al dire	ပ္	1 ☐ Yes 2 ☐ NA6			ER/Outpatie	nt 3□D	OA Othe	er: 4 Nu	rsing Hom	e 5□Res	idence 6	□Other (Sp	ecify)	
ding P	funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	f Injury n, <i>Day</i> , Yea <i>r)</i>	28b. Time of Injury		28c. Injury Work			Bd. Describe	how injury	occurred		
ttend	the 1	icat	2 Accident investig 3 Suicide 6 Could r	not be	of Injury . At h	omo form etr	M M		Yes 2 1		26	· · · · ·			
after Direc	d in by	Certification:	4 ☐ Homicide determ	ined buildin	g, etc. (Speci	ome, farm, str fy)	eet, lactor	y, onice		28	City or To	wn, State)	Number or I	Hurai Hou	ite Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Of the Funeral Director: Attent his certificate has been stoned by the attending physic	completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit		29a. Certifier 1 Certifyin	ng Physician: To the l	best of my kno	owledge, deat	h occurred	at the tin	ne, date an	d place, a	nd due to the	e cause(s)	and manner	as stated	l.
the H hin 24 the Fi	mplete	Medical	one)	and mann	miner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.						at trie time				
5 ¥ 5	00	-	29b. Signature and title of certified	1	1-1-	100	29	c. License	e number			29d. Date	signed (Moi	nth, Day,	Year)
			N.C.	clan F	TWO	ENT	リ	00	187	15		11	101/	15_	
31	25		30. Name and address of person William H. Woo		· ·	, , , ,	ŕ		. w	21.0	01				
	Sta	te	31. Date filed (Month, Day, Year)	32. R	gistrar's Signa	ins Lan			, MD	216	UI				
Re	egistr	_	DEC 0	1 2009	merca	A. A	acks								

09-09280 Jill Bee Newman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ll Bee Newman	1- For State Contificate of Death									
Physician Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death T-1-1-1 Poor Norman									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 9806 Dilston Road 4c. County of Death Montgomery									
Funeral Director	5. Social Security Number 217-48-8354  6. Sex 7. Age (in yrs. last birthday) 58 Yrs.  7. Age (in yrs. last birthday) 58 Yrs.  1 M 2x F  7. Age (in yrs. last birthday) 58 Yrs.  1 Months 58 Yrs.  1 Months 58 Yrs.  1 Months 58 Note of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) Cct. 3, 1951  Maryland	r Foreign								
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any matic event, the Medical Examiner must be notified at once. To Re Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Blace White, etc. 15. Page death of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 15. Page death of Hispanic Origin? (Specify Yes or No- White, etc.  16. Page death of Hispanic Origin? (Specify Yes or No- White, etc.	X No								
5-0036 ed within 72 hour tygiene. other than "natt										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Re Commit										
MOCE, Pages 1 an nent of Heal ant: If iten	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory  20b. Place of Disposition (Name of cemetery, crematory and place)  Metropolitan Crematory  20c. Location - City or Town, State  December 2, 2009  Alexandria, Virginia	а								
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate									
Physician /Medical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  Between Or Deat  Due to (or as a consequence of):  b.	nset and								
be executed sician and unial - transi										
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P.C es that es that igned!	1 Yes 2 No 3 Probably 4 Vu	nknown available								
Vital Records, seician: The law requires his certificate has been significator, page 2 should be the Commission		No								
27 Manner of Death 128a Date of Injury 128b Time of Injury 128c Injury at Work2 128d Describe how injury occurred										
Divi	2 Accident Investigation 3 Suicide 6 Could not be determined Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num or Town, State)	ber, City								
To the Hospital within 24 hours To the Funeral completely filled	1 29a Certifier									
	Sanuk Suchall, mr) O.C.M.E. November 30, 2009									
	30. Name and oddress of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Stat	31. Date filed (Month, Day, Year)  32 Registrar's Signatus									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 26. 2009 9:30 P M C. Nicholson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Golden Living Social Security Number 6. Sex. 1 Å M 2 ☐ F 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Dec. 20, New Jersey °1937 71 Director 156-28-8750 Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Frederick Frederick Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 30 North Place within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. 1 ☐ Never Married 2 🕅 Mamied ģ 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify White 3 Widowed 4 Divorced 1960 Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fis marked of ည Emanuella Hollinger permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic on Woodrow Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Bosc Court, Thurmont, MD 21788 Paul J. Nicholson / Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 11/30/2009 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatare of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Rept 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. If any leading to in medicause. Enter Underlying Exami -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page **V** No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this nin 24 hours after death. the Funeral Director: After thin npleted filled in by the funeral of 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at / Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

Lot

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

) BTE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registra 's Signature

Creena

KAZMI

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TOIL HOUSE

29d. Date signed (Month, Day, Year) -30-2009

TREDERICK,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D28, 2009 **Physician** Charles William Oyerly, November 7:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 317 Cone Branch Drive Middletown Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min 1X M 2□ F Days Hours 386-24-4861 July 9, Director 80 1929 Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre medical Examination multiples Director XTYes 2 No TN Wilson Mount Juliet 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 943 Point View Circle 37122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes \ 2 💥 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Executive Public Relations Auto Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles William Oyerly, Sr. Hester Marie Harper ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Carolyn Burton Oyerly/wife 943 Point View Circle Mt. Juliet, TN 37122 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Final Journey Crematory 11/30/09 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Going Home Cremation Service P.O. Box 784 Signature of Funeral-Service Licensee Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Leukemia month /Medical Due to (or as a consequence of): Examiner Myelodysplasia Sequentially list conditions, if any leading L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner certificate be executed Exami sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? The law requires that the death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No detached <u>P</u> 9 ☐ Unknown 9 Unknown signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s certificate 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Nome Hospital: 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67931 November 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 Sebastien Kairouz, M.D. 46B Thomas Johnson Dr. Suite 200 Frederick, MD 21702 egistrar's Signature State Registrar

	Ex	a	m	in
Division of Vital Records, P.O. Box 66/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	-	For State Registrar	State of Maryland	-	artment of H rtificate of L			jiene _{leg. No.} 200	19 40353		
Physicia	_	1. Decedent's Name (First, Middle, Last)  JOHN EDGAR OXLE	Y, JR.				2. Date of Dea	-	3. Time of Death		
/Medica Examine		4a. Facility Name (If not institution, give str 128 S. VAN BURE	·		4b. City, Town, or ROCKVII		th	4c. County of D			
Funeral Director		217-32-4173	7. Age (In yrs. k	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country) SH., DC		
e Maryland a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           MD         MONTGOM.		, Town or Lo					10d. Inside City Limits 1 □ Yes 2 □ No		
with the	al Dire	10e. Street and Number 128 S. VAN BURE	10f. Zip Code 20850			0g. Citizen of What					
ours after death with the Marylan ral", or Items 23a or 28a-f show Examination in till of at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: WHITE			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it effects that it is not be considered.	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)			dent's Usual Occupation kind of work done during most of working DO NOT use retired) RANCE AGENT			16b. Kind of Business/Industry  INSURANCE			
Mental Hyg Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last)  JOHN EDGAR OXLE	Y, SR.				ume (First, Middle, I BRANSON	Maiden Surname)			
and 2 sho ealth and m 27 Is m		19a. Informant's Name/Relationship (Type RUTH CROPLEY /	,		-			r, City or Town, Stat LLE, MD			
Pages 1 ment of H. ant: If Iten lury or oth		20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3 □ Report 4 □ Donation 5 □ Other (Specify)	moval from State 20b. Pl	lace of Dispo emetery, crer NUFFEI	osition (Name of matory or other plac R CREMAT	ORY 11	/30/09	20c. Location - City FREDERI	· ·		
permit. Departr Imports any Inje		21. Signature of Funeral Service Licensee	1	]	2. Name and Addres HILTON F P.O. BOX	'UNERAL	HOME ARNESVI	LLE. MD	20838		
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death disease or condition resulting in death)  a. CONGESTIVE HEART FAILURE  Due to (or as a consequence of):									
ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnal 1	death 3	☐ Ectopic pregnance	1		23d. Date of Month	delivery Day Year		
w requires that been signed b should be deta	\$	Part II. Other significant conditions control				Did tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
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siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Ho	spital:		Othe	D. W.	eath (Check only or				
nding Physician: ": After this certifica e funeral director,	ation: To	1   Yes   2   No			f 28c. Injur	4 ⊔ Nursing y at	Home 5 ☑ Aesidence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To							on (Street and Number or Rural Route Number, r Town, State)			
he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To t with To tl	Σ	29b. Signature and title of certifier  WWW.am. 15	Silvan	·	29c. Licenson	e number 10279		29d. Date signed (M	onth, Day, Year)		
10		30. Name and address of person who com WILLIAM SILVE	·			CKS RD.	, #111.	ROCKVII	20854		
Stat	е	31. Date filed (Month, Day Year)	32. Registra/s Signat	ture	,						

DHMH 17 Rev 1/2001

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	Phys	icia		Registrar  1. Decedent's Name (First, Middle,	Last)						te of Death	J. No.	<u> </u>	3. Time of E	Death
Me	dical Exa			ALYSIA	MODUPE OI	KANLAWON				De	onth cember	Day 6, 2009	Year	1835 h	rs
e e e e e e e e e e e e e e e e e e e				4a. Facility Name (if not institution, Shady Grove Adventist	give street and number		4	b. City, Town, or L Rockville	ocation of	Death			nty of Dea gomery		
	Funer	ral		Social Security Number 6	. Sex 7. Ag	ge (In yrs. last birt	hday)	If Under 1 Year	If Under		ate of Birth	(MM/DD/Y		Birthplace (State	e or Foreign
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	<b>6</b> ւ 72 հ an "n	cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during me	ost of working file.	DO NOT	use retired)					
	within yiene.	Medi	E I	12th 17. Father's Name (First, Middle, L				STUDENT				NONE			
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	212 ald be Menta	even		OMOLAJA OKANL  19a. Informant's Name/Relationship		19	b. Mailing	Address (Street	AJC and Num		JLAIMA		Town, Sta	ate, Zip Code)	
	AD 2 sho h and 27 is	mati		OMOLAJA OKANLAW	ON/FATHER	5	032	57th AVE	NUE E	BLADENS	SBURG	MARYI	LAND	20710	
	e, land I and Healt	rtra		20a. Method of Disposition		20b. Place	of Disposi	ition (Name of cem		Date				or Town, State	
	nor Pages ent of nt: II	othe		1 X Burial 2 Cremation 4 Donation 5 Other Spe		late	•	EAVEN_CE	ME.	12/15	/2006	CTIVI	עט מב	RING,M	ΔΡΥΙ.ΔΝΙ
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	1		2. Signature of Funeral Service Li	censee	TOTTE	_	ame and Address						AL HOM	
	E P E O	Ē		JE K			7	474 LAND	OVER						
	Physicia			23a. Part I. Enter the disease, or confailure. List only one cause or		d the death. Do no	ot enter th	ne mode of dying,	such as ca	ardiac or resp	iratory arre	st, shock, o	r heart		ate Interval Onset and
- n ·	/Medic xamin			Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								D	eath		
٠,		Н		,	Due to (or as a cons	sequence of):									
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	687 ertific ding p	e as th	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	Address of James		tal death 3	Ectopic	pregnancy		Mon	th	Day	Year
	Box 68760 e death certificate b the attending physic	for us	hysician/M	1 Yes 2 No 9 V Unkn		at time of death	5 Ott	ner (Specify)							
	O. Enat the d	ached	Δ.	Part II. Other significant conditio		th but not resultin	g in the u	nderlying cause g	iven in Pa	rt I.	23e. Did tot	pacco use c	ontribute	to the cause of	f death?
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	To the within 2	com	Med	29b. Signature and title of certifier	and manner stated			29c. License						Month, Day, Ye	ar)

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001 OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Zabiullah Ali, M.D.

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 7, 2009

OCME

Registrar
DHMH 17 Rev 1/2001

PAIRRAY

1 VA 22031

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD

22. Registrar's Signature

8301 ARLINATION

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygieney 40356 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Ernest James Prete  $P^{M}$ December 2009 8:08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3211 Roderick Road Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 M 2 □ F 119-20-5453 82 Director January 8, 1927 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d Inside City Limits 10a. State 10h County 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3211 Roderick Road 21704 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Wor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status World 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Completed by Specify: War II 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deputy Chief of Police Law Enforcement 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pietro Prete Congetta Perri ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Prete / Son 4714 Caleb Wood Drive, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If Ite any injury or ot once. December 9 1 Burial 2 □ Cremation 3 □ Removal from State Saint John's Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cutz disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Ch-umbocy 1 Tyes 2 ₹No 3 TProbably 4 TUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifie to the cause (s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 014626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 (2) St- Frederich 501 1905 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Beg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** GEORGIA В. PAYTON NOV. 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MAGNOLIA CENTER LANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 F Director FLORIDA 261-64-9928 68 JUNE 16, 1941 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 √Yes 2 No Directo PRINCE GEORGE'S MD. RIVERDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5409 RIVERDALE RD. #C-1 20737 U.S.A. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 ◯ Widowed 4 □ Divorced BLACK "natural", Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. POST OFFICE POSTAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked **GEORGE** BROWN OSSIE BELL ROBINSON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVONNE DIALLO/NIECE 9532 TEMPLE HILLS RD., CLINTON, MD. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If Its any injury or o once, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12-3-2009 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. Kamber a 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): UNKNOWN **Examiner** ULCERS PRESSURE ULTIPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) UNKNOWN The law requires that the death certificate be executed ACUTE CUA physician and s the burial-trans Due to (or as a consequence of) UN KNOWN MYPERTENSION Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HEART ONGESTIVE TAILURG 1 Yes 2 No 3 Probably 4 Unknown Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 22 No 1∐ Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Norsing Home 1 Yes 2 Ne 2 ☐ ER/Outpatient 3 ☐ DOA ² 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day,

Medical

DHMH 17 Rev 1/2001

Registrar

32 Registrar's Signature DEC 03 2009

CENTER

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENWAY

Year)

DRIVEI

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DU 063978

DR. HINA

SUITE 1051

29d. Date signed (Month, Day, Year)

30/2009

MB 20770

GREENBELT,

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		-	1. Decedent's Name (First, Middle, Last)	Timeate of Beath	2. Date of De	Reg. No.	3. Time of Death				
	Physici	an	JAMES HOWARD PALMER		Month NOV.	25, Day 2009 Year					
-	/Medic		4a. Facility Name (If not institution, give street and number)	4b City Town and another of 5			7:00 P M				
	Examin	er		4b. City, Town, or Location of D	Death	4c. County of Death					
-	Funeval		7104 Murphy Court  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hrs. 8 Date of Bir	Prince G	pplace (State or Foreign untry)					
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  86 Yrs.  16. Sex  17. Age (In yrs. last birthday)  18. Date of Birth (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  19. Bir (Month, Day, Year)  20. Bir (Month, Day, Year)  21. Bir (Month, Day, Year)  22. Bir (Month, Day, Year)  23. Bir (Month, Day, Year)  24. Bir (Month, Day, Year)  25. Bir (Month, Day, Year)  26. Bir (Month, Day, Year)  27. Bir (Month, Day, Year)  28. Bir (Month, Day, Year)  29. Bir (Month, Day, Year)								
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it with a strain and it will be usuiffed at	Funeral Director	10e. Street and Number 7104 Murphy Court	10f. Zip Code 20748	10g. Citizen of What Co	untry?					
	ms 2	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Uss Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No	- 14. Race - Ame	rican Indian,				
9	or ite	Ī	1 □ Never Married 2 ☑ Married   1 ☑ Yes 2 □ No		uerto Rican, etc.)		, etc.				
03	urs a	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 43-45	1 □Yes 2 ☑ No Specify:		Specify: Bla	ick				
21215-0036	72 ho	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of	f secondaina	16b. Kind of Business/I	ndustry				
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nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)	l l	Name (First, Middle,	*					
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Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, It. M. Once.			2. Name and Address of Facility 46 N. Washingto							
			23a. art 1. Enter the disease, or complications that caused the death on other shock, or heart failurs. List only on cause on each line.	ter the mode of dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between				
No.	Physician	2. 33		ncer			Onset and Death				
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	NICOL_		-					
	Examiner	H									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.								
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O. Box	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day <b>Y</b> ear				
σ.	that ned b deta		Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?				
of Vital Records	uires n sign lld be	d by	Hupenansur, warmy and	M chollal	1 🗆	Yes 2 □ No 3 □ Pr	obably 4 Unknown				
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Ė	iding Physiclan; th. After this certifica funeral director, p	Be c	examiner?  1 Yes 2 1440  Hospital: 1 Inpatient 2 ER/Outpatie	Othor:	f Death (Check only o						
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Ö	tal or after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or To	wn, State)					
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)				
	Vith To t	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)				
	5		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print) X 12018		14409					
			Glenn Edge combe my 770	Dold Brun	ch Alle	Clinton	mo 2073				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,-1/1/	)	17				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 26, 2009 08:55 S. Myrtle Purcel1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X F 06-07-1912 Maryland Director 213-22-5545 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Director Eden Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21822 USA 25361 Collins Wharf Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: <u>\$</u> 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 none Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Henry Royal Shaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance P. Moore/Daughter 25361 Collins Wharf Road, Eden, MD 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Allen Cemetery 11/29/2009 Allen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hinman Funeral Home Signature of Funeral Service Licensee M00295 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Ave., Princess Anne, 21853 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate the property of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? Hyperlipidemia 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1 ☐ Yes P After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. Division or Vital Records, P.O.

Baltimore,

To the Hospital or Attendi within 24 hours affer death. To the Funeral Director; A completely filled in by the ft

State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

and title of certifier Physician

09

and address of person who completed cause of death (Item 23a) (Type, Print)

J.C. Patrouicz, D.o. 1820 Sweet Boy Drive, Suite 101, Salistany, mD

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1:05 PM WARNER A. 20 PARKS, 2039 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Salisbur Wi Conico Hospice at If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 230-52-5778 67 August 18, 1942 Virgínia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Somerset Rhodes Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3460 Marsh Road 21824 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Vietnam 1 XYes 2 No II S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married U.S. 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warner Ames Parks Estha Lee Crockett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Parks (Wife) 3460 Marsh Road - Rhodes Point, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 11/21/09 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature F ner Service 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINDMA MALIGNANT disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and the list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) (+05/10/2 1∐ Yes 2 🖽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, Ital Once.

Baltimore, Maryland 21215-0036

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requires that the death certificate be executed

Hospital or Attending Physician; The law

After 1

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24 hours after death Funeral Director: filled in by the

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Box 68760

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Records,

Division of Vital

Physician/Medical \$ Completed

Be

Certification: To

Medical

State Registrar

1 Natural

∠ □ Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

28a. Date of Injury (Month, Day, Year) investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

citifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Stuly sury

29d. Date signed (Month, Day, Year)

30. Name and addre is or person who completed cause of death (Item 23a) (Type, Print)

WAWIS 0 1800 6 Huyan 32. Reginar's Signature

31. Date filed (Month, Day, Year)

5 Pending

6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Howard Lewis Penn 2009 5:35 P M Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Nov. 09, 1946 402-64-5438 1 🛛 M 2 🗆 F 63 Director New Jersey Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mential Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD Arnold 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 160 Tall Tree Trail 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Naval Academy Mathematics Professor '5± Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Herman Penn Ida Evantoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
160 Tall Tree Trail Arnold, MD 21012 Beth A. Penn / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, INC. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Nov. Date 25 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician - S FONARY ARTERY disease or condition resulting in death) ZOYERRS ) Medical Due to (or as a consequence of) Examiner LIPIDEM FR Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death 1 Yes 2 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate h 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 1 Tes 2 1 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

RUBINSON

ROAD, SEVERNA PORK, MM

21146

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

my

32. Registrar's Signature

WATZ

STEDITEN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 30 per DVR G898 12/23/09 dk
State of Maryland Department of Health and Mental Hygiene

			_ For	State of M	arylan	dy Bepa	artment of F	ealth a	and Mental	Hygiei	ne) (	119	40362	
			State     Registrar			Cer	tificate of E	Death		Reg.			40002	
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)					2. Date o		Dov	Voor	3. Time of Death	7
	Medic		<u>Charles</u>	W.			Putman	<u>.</u> .	Nover	ber	28 <b>,</b>	2009	5:20 P M	
	Examin	er	4a. Facility Name (if not institution,				4b. City, Town, or		of Death			nty of Death		1
7.			15202 East Cato  5. Social Security Number			ghway st birthday)	Thurmo	nt If Under 2	24 Hrs. 8. Date o	f Diah	Fre	deric		4
	Funeral Director		215-36-6616	1 X M 2 □ F	97	Yrs.	Months Days	Hours	Min. (Month	, Day, Yea	ar)	9. Birth Coun Mary	place (State or Foreign stry)	
			Usual Residence of Decedent						INOV	.0,19	12	mary.	Land	╛
yland	f sho	to	10a. State 10b. County			, Town or Loc						1	10d. Inside City Limits	1
Mar	28a- notifi	Director	Maryland Freder	ick	Th	urmont							1 ☐ Yes 2 🖾 No	_
with th	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at, once,		15202 East Cato	ctin Mountai	n Hig	shway	10f. Zip Code 21788			10g.		of What Cour USA	ntry?	
death	items ier mi	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S		Vas Decedent of Hi	spanic Orig	gin? (Specify Yes or , Puerto Rican, etc.	No-		ace - Americ		1
after	l", or xamir	Completed by	1 ☐ Never Married 2 😾 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Yes 2 X	No		☐ Yes 2 🏋 No				Speci	lack, White, ifv· Wh:	etc. ite	
S sno	atura cal E	ete		Year or Dates.  ht's Education			lent's Usual Occup			401				4
2 12 L	an "n Medi	ם	(Specify only highe	st grade completed)  College (1-4 or 5		(Give k	kind of work done of NOT use retired)		of working	100	o. Kina of	Business In	dustry	Ĭ
withir	giene er th		Elementary/Seconday (0-12)	College (1-4 of 5	)+)	Pai	inter			Co	nstr	uction	n	
e filed	tal Hy ed oth event	To Be	17. Father's Name (First, Middle, L Raymond	ast) Cleveland	τ	utman		18. Mothe Bert	er's Name (First, Mic	idle, Maid		_{me)} mermai	n	
	d Men narke natic	-												$\dashv$
2 sho	Ith and		19a. Informant's Name/Relationsh Susan Favorite/I			1	g Address (Street a		r or Rural Route Numont, MD			, State, Zip (	Code)	
and and	f Heal item : other		20a. Method of Disposition			lace of Dispo	sition (Name of		Date			n - City or To	own, State	4
Dallill Dage 1	nt: If		1 ♣ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			-	natory or other place		2/2/2009			ick, l		
alit. F	Departm Importa any inju once,		21. Signature of uneral Service L		TIC.				Stauffe					1
	a la		Alan Sa	rden		- 4			reet Thu					
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	d the death								Approximate Interval Between	1
	ysician/		Immediate Cause (Final disease or condition	Hyperto	mou	e Co	ulio Va	seula	D Dis	nd		1	Onset and Death	1
	Medical xaminer		resulting in death)	to (or as	a consequ	ence of):								
		Jer	Sequentially list conditions,	b. Due to (or de	a nonegau	ence chi						-		-
rted	d ansit	dical Examiner	Sequentially list conditions, if any, leading to finned at cause. Enter Underlying Cause (Disease or iinjury that initiated events											
exec	an an irial-tr	Ĕ	resulting in death) Last	Due to (or as	a consequ	ence of):							-	
te be	ohysician and the burial-transit	dice		d										4
ertifica	attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv								٦
ath c	atten for us	ciar	23b. Was decedent pregnant in the past 12 months?		2 Feta	I death 3 🗌	Ectopic pregnance Other (specify)	У				Date of deliv Month	ery Day Year	ĺ
he de	signed by the s be detached l	hysi	1  Yes 2 No 9 Unknown	9 🗆 Unknown										
that	ned be deta	by P	Part II. Other significant condition	ns contributing to death b	out not res	ulting in the u	nderlying cause giv	ren in Part I	23e. I	Did tobaco	co use co	ntribute to th	he cause of death?	1
Ordo, v requires	s been sig should b	ted							— ∥ ¹	☐ Yes	2 No	3 🗆 Pro	bably 4 🗆 Unknown	
	has be je 2 sh	Completed						_	— l :	Nas an autopsy	- 1	prior to ca	psy findings available impletion of cause of	
ב ב <u>ּ</u>	cate h								1 🗆	performed Yes 2	? No	death?	2 No	_
ician	certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Oth		th (Check only one)					4
Phys .	r this eral di	2	1 Yes 2 No 27. Manner of Death	1 Inpati		ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun	4	rsing Home 5 X				<u>/)</u>	$\dashv$
ending	ath. r: Afte e fune	Certificate	Natural 5 Pendir		y, Year)	injury	work	? Yes 2 🗌	1	ibe now ii	ijury occi	arred		
r Atte	recto recto	ertif	3 Suicide 6 Could 4 Homicide determ				eet, factory, office			on (Street		nber or Rura	l Route Number,	
ital o	urs aff ral Di lled in			()										
Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check 🛮 🗠 L Medical E	Physician: To the best of examiner: On the basis of e Nurse Practioner: To the	xamination	-and/or invest	igation, in my opinio	n, death oc	curred at the time, of	ate and pl	ace, and o	due to the ca	use(s) and manner stated	1.
To the	withir To the comp	2	29b. Signature and title of certifier		DOUG OF THY	Tallowing Uge, C	29c. License	number			· · · · <del>-</del> ·	ned (Month,		_
			> Xxhibo	1. Kaysm	m	-mo	D-1	1397			11/3	0/09	7	
	1		30. Name and address of person	\ /			*				1	<del>-//</del>		
	`		Robert L. Kauf		_		treet, F	reder	ick, MD 2	1701				4
	Stat	te	31. Date filed (Month, Day Year)	0 1 2000 32. Registri	s Signat	ure	how that							

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 Joseph Pere R. November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) an. 8, 1934 Months Days Hours Min. Director 126-26-2703 Jan. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 241 East Second Street 21701 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 No ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1954–60 1 ☐ Yes 2 K No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Joseph Pere</u> Edith Ernhout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Pere / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.12/1/2009 22. Name and Address of Facility Stauffer Funeral Homes P. A. 21. Signature of Juneral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colon Cancer Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examine physician and sthe burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ signed by the atte in the past 12 months? 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a Was an has performe Yes 2 X No Be 25. Was case referred to medical **Division of Vital** funeral director. 26. Place of Death (Check only one) examiner's Hospital Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Just death. **I Director: After the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fire the fi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at I or Attending I after death. 1 K Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Hospital 624 hours a Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

East Second Street, Frederick, Maryland 21701 20c. Location - City or Town, State Frederick, Maryland 1621 Opossumtown Pike, Frederick, Maryland21701 Interval Between Onset and Death Minly S 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the last of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifyin, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou House Ave 801 32. Registrar's Signature backs **ORIGINAL** 

2009

Black, White, etc.

Contractor

White

Frederick

New York

7:30a

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Registrar

State

Lucy

31. Date filed (Month, Day, Year)

Cardi MA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4:25 a^M Harris Daeng Parani December 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11508 Veirs Mill Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Director 50 218-61-8582 August 14, 1959 Russia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11508 Veirs Mill Road 20902 Indonesia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🛣 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Self Employed Media 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant; If item 27 Is marked or ည Muhammad N. Daeng Parani Siti Ruktah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muhammad Tenriola - Brother 2900 Blue Ridge Avenue, Silver Spring, Maryland 20902 Department of Heal Important; if item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Alhamdulillah the 12/02/2009 4 Donation 5 ☐ Other (Specify) Frederick, Maryland Al-Firdaus Mem. Gardens 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** CENE disease or condition resulting in death) bro Vasc mE /Medical Due to (or as a consequence of): Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (but as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed? Yes 2 No certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospîtal: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3□ Suicide 6 □ Could not be 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: Ann he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 290 Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) ファナ28 MODE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO DME VEY 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	eartment of Health and Mertificate of Death	_	iene 9. No. 2 0 0	9 40365
Physicia		Decedent's Name (First, Middle, Last)     THEODORE JAMES QUEEN		2. Date of Death Month NOVEMBE	R 29, 2ŏ	3. Time of Death 12:35 AM
/Medic Examin		4a. Facility Name (If not institution, give street and number)  GENESIS HEALTHCARE CENTER	4b. City, Town, or Location of Death  LA PLATA		4c. County of CHAR	Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 120–32–6378 1 X M 2 G F 75 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, AUGUST 17	, 1934 M	. Birthplace (State or Foreign Country) IARYLAND
Maryland -f show fied at	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L           MARYLAND         CHARLES         INDIAN HI				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the a or 28a	Director	10e. Street and Number 5655 MASON SPRINGS ROAD	10f. Zip Code 20640		Og. Citizen of Wh	at Country?
ite, will yially ZIZIS-DOSO  1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral I	11. Marital Status  1 Marital Status  1 Married   12. Was Decedent Ever in U.S. Armed Forces?  1   Yes   2 Married   1   Yes   2 Married   1   Yes   3 Molifyes   3 Married   1   Yes   3 Married   1	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race -	American Indian, White, etc.
hin 72 hours e. an "natural" Medical Ex	Completed b	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		16b. Kind of Busin	BLACK ness/Industry
yidilia Kirki buld be filed withi Mental Hygiene. arked other than attc event, the M	Ве Соп	6TH GRADE LAI  17. Father's Name (First, Middle, Last)	BORER 18. Mother's Nam	e (First, Middle, N	CONSTRU faiden Surname)	CTION
should be and Mental s marked o umatic eve	To B	JAMES HENRY QUEEN	MARY MAD			
E, INIAL Tand 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Type. Print)  RUTH D. BUTLER / SISTER  19b. Mai  34 JA	ting Address (Street and Number or Rui AMESON COURT, INDIA	AN HEAD,	MARYLAN	ate, Zip Code) D 20640
Pages 1: nent of He int: If Iten ury or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition cemetery, cree  ST. CATHER	osition (Name of ematory or other place)  INE®S CEMETERY DEC.		20c. Location - Ci	
partilling is, interpretable between the permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other transpace.		21 Analyse of Flueral Symmetries e LYDIA C. THORNYON JOHNSON MOO583	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon			
Physician /Medical Examiner  Physician and Examiner the parial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not explose, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):  CAROLOMO  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	nter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death Now ITE
eath certifi attending p	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of Montil	
w requires that the d	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			ute to the cause of death?
The law req	Completed			24a. Was ar autops perforn 1 □ Yes 2	y prid ned? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 □ No
hysician: The Is nis certificate ha I director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other:	h_(Check only one	_	(Specify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification: T	27. Manner of Death  1  Natural 5  Pending (Month, Day, Year)  2  Accident investigation investigation	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe ho		
tal or At s after d al Direct	Certifi	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town		or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, dea  2  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the c red at the time, d	ause(s) and mani ate and place, an	ner as stated. d due to the cause(s)
To with	Ž	29b. Signature and title of certifier Kelly Mo	29c. License number  DOOGGOI  A. Print)  A. Print)  A. Print)	8	9d. Date signed (	Month, Day, Year) 30-2009
4		30. Name and address of person who completed cause of death (Item 23a) (Type RICH ARD THEIR LOGGENERAL)	y Dock Rd, King	GARGE	UD_	22485
Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 0 2 2009  Access B.	parel	-		

DHMH 17 Rev 1/2001

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			For State	St	ate of Mar	yland / [	Departme <i>Certific</i>		ealth and I	Mental Hy		/ U U 9	4(	366
		. 2	Registrar  1. Decedent's Name	e (First, Middle, Last)			Certino	ale of L	Jeani	2. Date of D	Reg. No.		3. Tin	ne of Death
п	Physici /Medio		PHILIP	EULON	RATCI	LIFFE,	JR			Month NOVEMB	ER 22		/:	42 AM
Mark Comment	Examir			f not institution, give street	and number)			ity, Town, or	Location of Death	1	4c.	County of Dea	th	
	Francis		5. Social Security N	TON CLIFF RO		'In yrs. last bir		der 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	FALBOT 9. Bir	thplace (Si	ate or Foreign
	Funeral Director		216-28-3	1 XM	2□ F 7		Yrs. Mont	hs Days	Hours Min.	MAY 20	, Year) , 19:	C	ountry) RYLAN	
	put M		Usual Residence of 10a. State		11	0c. City, Towr	or Location						10d Insid	de City Limits
	Maryla f sho	to	MARYLAND	TALBOT		EAST								Yes 2 KNo
	r 28a	Directo	10e. Street and Nur	mber		2021		Zip Code	·		10g. Citi	izen of What Co	ountry?	
	23a c		6077 во	STON CLIFF R	OAD			21601				TED STA	res	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exprinter marker	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 X Married 1	las Decedent Evermed Forces? Yes 2 □ No Yes, Give ear or Dates:	er in U.S.		cedent of Hispecify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: WH	e, etc.	n,
5-0	72 ho	Completed	(Spec	15. Decedent's Education cify only highest grade com	n npleted)	16a.	Decedent's L (Give kind of	Isual Occupa work done d	ation  uring most of work 	king	16b. Ki	nd of Business	/Industry	
2121	within iene.	dmo	Elementary/Seco		ollege (1-4or 5+)	СН			OFFICE		1	PERTY ELOPMEN	r	
d 2	filed I Hygi	Be Co	17. Father's Name	(First, Middle, Last)		<b>VII</b>	III IIII		18. Mother's Nam		1		ı.	
ılan	should be fi and Mental I s marked of umatic ever	To B	PHILIP	EULON RATCL	IFFE				ISAB	ELLE YO	UNG			
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	s 1 and 2 of Health item 27 i		CAROLE R 20a. Method of Dis	ATCLIFFE/WIF					LIFF ROAL	Date		<b>D</b> 2160 cation - City or		10
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Н			shock, or hea	he disease, or complication ort failure. List only one car	ns that caused thuse on each line.	e death. Do							Approx Interva	imate I Between and Death
1	Physician /Medical		Immediate Cause disease or condition resulting in death)			TOCE		RCA	trei no	44				YEAR
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60,	sician burial	_	,		Due to (or as a c	onsequence	л).							
687	tificate g phys as the	edic		d										
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12	months?	yes, outcome of Live birth 2	Fetal death		ic pregnancy	,			23d. Date of de	elivery Day	Year
o.	at the de by the a tached f	ıysic	1 □ Yes 2 □ 9 □ Unknown	□No 4	☐ Pregnant at tir ☐ Unknown	me of death	5 ☐ Other	(specify)						
٦,	res that igned b	by Ph	Part II. Other signif	ficant conditions contribut	ting to death but r	not resulting ir	the underlyin	ig cause give	en in Part I.	23e. Did	tobacco u	use contribute t	o th <i>e</i> cause	of death?
Vital Records,	w require been signated should b					· ···· · · · · · · · · · · · · · · · ·				1 🗆	Yes 2	No 3□ F	robably	1 Unknown
Sec.	law r has be e 2 sh	Completed								24a. Wa auto	psy	prior to	completion	ings available of cause of
al F	sician: The law certificate has rector, page 2 s		05.146							1 □ Yes		death? 1 □ Ye		-
	ysician: is certific director,	o Be	25. Was case refer examiner? 1 ☐ Yes 2	111	al: 1 ☐ Inpatient	2 □ EB/Oι	tnatient 3 🗆	DOA Othe	26. Place of Dea			6 ☐ Other (Sp	acifu)	
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siol	eat or:	catic	2 ☐ Accident 3 ☐ Suicide	investigation			М	1 🗆 \	/es 2 □No					
Division	after de Direct	Certification:	4 ☐ Homicide	determined 28	e. Place of Injury building, etc. (	- At home, fa (Specify)	rm, str <i>ee</i> t, fac	tory, office		28f. Location City or To	(Street an wn, State	nd Number or F e)	ural Route	Number,
_	To the Hospital or within 24 hours after To the Funeral Directory (Completely filled in b	Medical Co	29a. Certifier (Check only one)	1X Certifying Physician 2 Medical Examiner:	n: To the best of each of the basis of each of the basis of each of the basis of each of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the bas	xamination ar	e, death occur id/or investiga	red at the tin tion, in my op	ne, date and place pinion, death occu	e, and due to th	e cause(s	s) and manner a d place, and du	is stated. e to the ca	use(s)
_	vithii Vomp	M	29b. Signature and	title of certifier				29c. License			29d. Da	te signed (Mon	1	ar)
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	50+1			ress of person who comple				5017	E 300 L	ות זארלט	ILLS	мь	2109	3
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	Registr	ar		10 4 3 0 2009	32. Registrar's	J. B.	garl							

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Earnest Rephann A M December 2009 5:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 138 East Ave. Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of bits. (Month, Day, 2.5 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 MM 2 - F Months Days Hours Min. Director 220-16-7050 Dec 85 Usual Residence of Decedent show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Washington Maryland Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 138 East Ave. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or ۾ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Adiuster Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be filed Fealth and Mental H Tem 27 is marked ot Lee Rephann Gladys Eisel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health (Important: If item 27 Linda K. Thomas / P.R. East Ave. C/O P.O. Box 2191 Hagerstown Md. 21742 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ò Smithsburg Crematory 12/8/2009 Smithsburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ orilmone disease or condition resulting in death) ) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No Yes 2 No or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 medical 4 derce 3H-5+ 111 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Box 68760

of Vital

Division

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State of Maryland / Department of Health and Mental Hygiere 0 0 9

	1 = For State Registrar	otato ot maryta.	Certificate of	Death	Reg. No.		
Dhusisian	1. Decedent's Name (First, Middle, L	ast)			ate of Death	Year	3. Time of Death
Physician /Medical	Henry Stanislau	s Romanowski,	Sr.		ember 5,	2009	12:15 P M
kaminer	4a. Facility Name (If not institution, g			or Location of Death		County of Death	
	14717 Warfordsbu		Hancock			shington	
al or	5. Social Security Number 6. 216-12-2582  Usual Residence of Decedent	Sex 7. Age (In yrs. 1 Mg M 2 G F	86 Yrs. If Under 1 Year Months Days	Hours Min. (N	ate of Birth fonth, Day, Year) 19 15,192	Cour	
	10a. State 10b. County	10c. C	ity, Town or Location			1	0d. Inside City Limits
ō	MD Washin	gton Har	ncock				1 ☐ Yes 2 No
Director	10e. Street and Number		10f. Zip Code		10g. Citiz	en of What Cour	ntry?
alD	14717 Warfordsbu	rg Road	21750		US	A	
Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Decedent of H	Hispanic Origin? (Specify Y an, Mexican, Puerto Rican	es or No- 1	4. Race - Americ Black, White,	
þ	3 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No			Specify: Whi	
Completed	15. Decedent's (Specify only highest g		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of working	16b. Kin	d of Business/Inc	dustry
du	Elementary/Secondary (0-12)	College (1-4or 5+)	Longshoreman	d)	Loca	1 #333	
	11 17. Father's Name (First, Middle, Las	et)	Longshoreman	18. Mother's Name (Firs			
Be	Frank Romanows			Vera Peplo		, , , , , , , , , , , , , , , , , , , ,	
ဥ	19a. Informant's Name/Relationship		19b. Mailing Address (Street			Town, State, Zip	Code)
	Mary Veronica Ba		14717 Warford				
	20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place			ation - City or To	
	1 ABurial 2 Cremation 3 14 Donation 5 Other (Spec	Linemoval nom State	Andrews Catholi		009 Wayne	shoro.	PΑ
	21. Signature of Euneral Service Lice		22. Name and Addre		-		
	11/18	1	260 Grove Fune:	141 W	est Main .Hancock.	Street MD 217	50-0368
T	23a. Part1. Enter the disease, or co	mplications that caused the dea					Approximate Interval Between
	shock, or heart failure. List onli Immediate Cause (Final		ADRIN THALA				Onset and Death
	disease or condition resulting in death)	a. Due to (or as a consec	ARRIYTHMIA				
			4			į	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quanca of).				
Examiner	Cause (Disease or injury that initiated events	C					
	resulting in death) Last	Due to (or as a consec	quence of):				
Medical		d					
	IF FEMALE:						
Physiclan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta	al death 3 Ectopic pregnancy	y	2	<ol> <li>Date of deliver</li> <li>Month</li> </ol>	Pry Day Year
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o	death 5 Other (specify)				
		contributing to death but not re-	sulting in the underlying cause gry	ven in Part I. 2	3e. Did tobacco us	e contribute to the	ne cause of death?
d b	ATRIAL FIGRIUM			LUNE	1 ☐ Yes 2 ☐		ably 4 Unknown
Completed by	140 PER-500 91/00						
ם	- Hyprercassia	1 12d701610d	OAL IL		4a. Was an autopsy performed?	prior to condeath?	psy findings available mpletion of cause of
-					☐ Yes 2 1 No	1 🗆 Yes	2□ No
Be	25. Was case referred to medical examiner?	Hospital:	- Oth	26. Place of Death (Che			
2	1 Yes 2 No 27. Manner of Death	1 Impatient 2	ER/Outpatient 3 DOA 28b. Time of 28c. Injur	4   Nutsing Home	Residence 6 Describe how injury		y)
ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury Wor	yar rk? Yes 2 □ No	reaction flow injury	occurred	
icat	3 ☐ Suicide 6 ☐ Could not	ha			ocation (Street and	Number or Rura	al Route Number
Certification:	4 Homicide determine	building, etc. (Speci	nome, farm, street, factory, office fy)		ity or Town, State)	Trumbur or Flore	a riodio riambor,
	29a. Certifier 1 Certifying F	hvsician: To the best of my kn	owledge, death occurred at the til	me, date and place, and di	ue to the cause(s) a	and manner as s	tated.
edical	(Check only one) Medical Exa	iminer: On the basis of examination and manner stated.	ation and/or investigation, in my o	ppinion, death occurred at	the time, date and	place, and due to	the cause(s)
Μe	29b. Signature and title of certifier	BRIAN R. STA	NUY MD 29c. Licens	se number	29d. Date	signed (Month,	Day, Year)
	1 / L. M.	- M	7)	58117		12/7/201	16
	30. Name and address of person who	completed cause of death //te	m 23a) (Type, Print)	~		• 1	7
	130 WES7 1/1	2. 00 . 1.	MANCEUR MD	21750			
ate	31. Date filed (Month, Day, Year)		ature				
trar	DEO 4 17 2000	A.L. A.	ature				
/2001	THE F. L. COLUMN	Show to	17				

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 MD 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F 217-54-6279 59 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10h County 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hyglene. Health and Mental Hyglene. Health and Mental Hyglene. The Research is marked other than "natural", or items 23a or 28a-f show the traumatic event, Ite Medical Exercity. WV Mineral Ridgeley 1 ☐Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 3 Box 685 A 26753 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
 1 Yes 2 No 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: Completed by Vietnam 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Explosive Machinist Alliant Tech, ABL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Ryan, Sr. Iris Lorraine Rexrode Ryan ပ္ 19a. Informant's Name/Relationship (Type. Print)
Billie Jo Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 3 Box 685 A Ridgeley WV 26753 wife Ridgeley item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/7/2009 Sunset Memorial Park MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer I Service Liona 22. Name and Address of acility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Interfile viseare, or cor p cationships, or he rt ailure. List on line ca s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Imme te Cau e (Final disease or con itic resulting in de th) Physician Yocardea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unverying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed A burns after death. Execution of the this certificate has been signed by the attending physician and telely filled in by the futneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown nis certificate has been signed by director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2/21No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2-☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0039811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADAMS M.D. 12500 WILLOWBROOK RD, COMBERLAND MD 21502 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER Physician/ RUMSEY 2009 STELLA 7:55 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL FOREST HILL HEALTH & REHABILITATION 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OCT 25, 1929 Hours 1 □ M 2 💢 F MARYLAND 80 213-30-6237 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director MARYLAND HARFORD HAVRE DE GRACE 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral UNITED STATES 21078 614 MARKET STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No AFRICAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates AMERICAN 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCTION WORKER FOOD PACKAGING 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARVEY DURBIN RUMSEY ESTELLA RUMSEY permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLES F. RUMSEY / SON 921 WALKER STREET, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State R.A. FERRIS & CO. 12/07/09 WEST CHESTER, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 21078 Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and defected for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has completed filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 1 Yes 2 No Accident Suicide Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, decard occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar

MACPHAIL ROAD - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DUNN - 615 W.

2275

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland /		rtment of H tificate of L		viental Hy	giene Reg. No	2009	40371
			Decedent's Name (First, Middle	, Last)					2. Date of De Month			3. Time of Death
	Physicia /Medic		Chhan Ros						November	2	4 2009	19:45 PM⁴
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aft.	Funeral		Holy Cross Hospit 5. Social Security Number		e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th V	9. Birthp	lace (State or Foreign
	Funeral Director		218-98-6087	1 ₹ M 2 □ F	94	Yrs.	Months Days	Hours Min.	January	' I,	1915 Ca	mbodia
	pu \star		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lor	cation				1	0d. Inside City Limits
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	r 28a-	Director	Maryland Montgo	allet y	ROCK	VIIIC	10f. Zip Code			10g. Ci	itizen of What Cour	ntry?
	th with		12500 Turkey Bra	anch Parkway				)853			No	
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, Inclination Everyland in the invition	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Decedent & Armed Forces? ed 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Hi fYes, specify Cuba □Yes 2¶ No	spanic Orlgin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Americ Black, White, Specify: As	
21215-0036	2 hou ratura icel E		15. Decedent	's Education	1 1	6a. Deced	lent's Usual Occupa	ation	kina	16b. k	Kind of Business/In-	dustry
21	ithin 7 ne. nan "r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done of 00 NOT use retired loyed	)	King	N N	//A	
2	iled w Hygier ther th	Ö	17. Father's Name (First, Middle,	( ast)			Joycu	18. Mother's Nan	ne (First, Middle			
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Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	۴	19a. Informant's Name/Relations	nip (Type. Print)			•				or Town, State, Zip	Code)
Σ,	and 2 ealth a n 27 i		Michael Ros - Son				lind Song Wa					01-1-
altimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State			sition (Name of natory or other plac	i .	Date		ocation - City or To	
Ħ	iit. Pa artmer artant: njury		4 □ Donation 15 □ Other (S)  21. Signature of Funeral Service			0.0	rematory, In		9/2009	GI	en Burnie,	Maryland
Ba	permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of American Service	215	MO1283	3   I	Teck Funera	al Home, L		Mar	yland 2070	7
			23a. Part 1. Enter the disease, r shock, or heart failure. List	omplications that caused	the death. [	Do not ent	er the mode of dyin	g, such as cardia	or respiratory	arrest,	J. 1211 11 12 12 12 12 12 12 12 12 12 12 1	Approximate Interval Between
a, F	Physician		Immediate Cause (Final disease or condition	Pneum								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as								
		ē	Sequentially list conditions,	b. Due to or as	iovascul a consequen		cident					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.								
ó,	e exe	I Ex	resulting in death) Last	Due to (or as	a consequen	ice of):						
68760,	ficate be executed physician and s the burial-transit	dical		d								
O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal de	eath 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у			23d. Date of deliv Month	ery Day Year
σ.	iires that t signed by d be detac	by Ph	Part II. Other significant condition	ons contributing to death b	out not resultir	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	he cause of death?
rds	w requires been sig should be								1 🗆	Yes	2 □ No 3 □ Pro	bably 4 X Unknown
Œ	The lite h	Completed					-		24a. Was auto perl 1 □ Yes	psy ormed?	prior to co death?	opsy findings available ompletion of cause of 2 No
Vital	nysiclan: Th nis certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Linesitale	ent 2 EF	VO 4	Oth	er.	ath (Check only		C DOther (Con-	(f. 1)
of	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Inju	ury 28	Bb. Time o			28d. Describe		6 ☐ Other (Specury occurred	(II)
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Division	or Attenction that the death virector; in by the	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   26e. Place of in	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or Rui ite)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Certifyii	ng Physician: To the best	of my knowle	edge, deat	h occurred at the ti	me, date and place	e, and due to th	e cause	(s) and manner as	stated.
	n 24 h	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination	n and/or ir	ovestigation, in my	pinion, death occ	urred at the time	e, date a	ind place, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifie	1120			29c. Licens				Date signed (Month) $11/24/2009$	, Day, Year)
	1) []		У	Musse	2		D692	.00 			11/24/2009	
•	XH		30. Name and address of person					enrine Mor	rvland on	010		
	Sta	ate	Yodit Negusse 31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur	EII NOA	d, Silver S	binis, tar	y Louis ZC	77 <b>I</b> U		
	Regist	rar	DEC 01	2009 Jane	rar's Signatur	1. 4	arke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kobinson AM November 25, - 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Place Hushesville 6150 8. Date of Birth (Month, Day, 3/3) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign -7. Age (In yrs. last birthday) **Funeral** Days Marzyhnd Months Hours Min. 1 □ M 2 1 87 219-16-1882 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐XYes 2 ☐ No Directo Charles Hughesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event. 6150 Nubian Place 20637 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Federal Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Thomas Maggie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6150 Nubian Place, Hughesville MD 20637 Joseph L. Thomas/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St.Marys Church 12/3/2009Bryantown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 MO1589 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arrest Immediate Cause (Final disease or condition resulting in death) respirations **Physician** 10010 /Medical Due to (or as a consequence of): Advance Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 \( \sum \) Yes 2 \( \sum \) No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknow been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1∐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066

State Registrar

DHMH 17 Rev 1/2001

Avan

31. Date filed (Mo

parks

22650

32. Registrar's Signature

Cedar have Court POBOX 404 Leonardtown Mi)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

Examiner and Division of Vital Records, P.O. Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be the signed by has this Director: d in by the f 24 hours af Funeral Dietely filled in

Examiner Certification: To

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

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Completed

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

and Mental Hygiene.

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Department of Health ar
Important: If Item 27 Is
any injury or other trau

**Physician** 

/Medical

Physician/Medical

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State Registrar

a ☐ Unknown þ Completed Be (

29a. Certifier

25. Was case referred to medical examiner? 1 ∐ Yes 2 🛂 No 27. Manner of Death 1 Natural

2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Ave

Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

La Plata

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dressian *btainrais* 31. Date filed (Month, Day,

and manner stated.

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** FLORENCE RAINEY NOV. 28, 2009 8:53 LEWIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Yrs. Director 321-52-9370 AUG. 9, 1958 ILLINOIS Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director ty Yes 2 □ No MD. PRINCE GEORGE'S LAUREL 10e. Street and Number 10g. Citizen of What Country Completed by Funeral 3358 OLD LINE AVE. 20724 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1♥ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1990-1 ☐Yes 27 No Specify: 3 Widowed 4 Divorced 2004 BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. PUBLIC HEALTH ENVIRONMENTAL ENGINEER <u>SERVICES</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Ith and Mental 27 is marked of traumatic ever **THOMAS** JAMES LEWIS MELBA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any injury or other trau
once. ROBERT RAINEY SR./HUSBAND 3358 OLD LINE AVE., LAUREL, MD. 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) ARLINGTON NAT'L. CEM. 12-30-2009 ARLINGTON, VA. 22. Name and Address of Facility CHAMBERS FUNERAL 5801 CLEVELAND A 21. Signature of Funeral Service Licensee AL HOME & CREMATORIUM, P.A. AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 2-3 DAYS /Medical Due to (or as a consequence of): Examiner COMPLICATIONS OF MULTIPLE SCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 SEIZURES 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? RECENT PULMONARY EMBOLISM 24a. Was an autopsy 2 🗆 No 2**X**□ No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1X Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5+1 NOV. 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. NIERODA, M.D. 7300 VAN DUSEN RD., LAUREL, MD. 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Shau November **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days 08-7-1943 VIRGINIA Director <u>231-54-4040</u> 66 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at 1 Yes 2X No Director EASTON MD TALBOT 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 2 U.S.A. 21601 25989 MARENGO ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 0 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 2 3 Widowed 4 Divorced WHITE "naturaf", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4 or 5+) 4 AGRICULTURAL SUPPLY OWNER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item Z7 is marked other any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ROGER ALDEN SHAW MARIAN PORTEWIG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25989 MARENGO ROAD, EASTON, MD 21601 ELIZABETH A. SHAW/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20a, Method of Disposition 20c. Location - City or Town, State EASTON, MD 12/3/2009 Donation 5 Other (Specify) WOODLAWN MEM. PARK FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate strength of the complete Course (Figure 1). 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Mulhorgan /Medical Due to (or as a consertence of) **Examiner** epsis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due o or as a consequence of leukemia myeloid acute and use as the burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes after death.

Director; After this certificate or Attending Physiclan; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2XNo Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Nes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide io the Hu.
within 24 hours.
To the Funeral D'
'etely fille 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD MPH November 28 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5RS MPH Orecki MD Zoe 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 29, **Physician** George Selwyn Swarth 2009 10:10 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care-Chevy Chase Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Oct. 17, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months California 546-20-2022 1 → M 2 □ F 98 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Exeminatings by notthed at 1 ☐ Yes 2 No Director Maryland Montgomer Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1415 Crestridge Drive 20910 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. Specify: White ₹ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, Ith. Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Schelwald Swarth Winifern Wood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher W. Swarth/Nephew 1415 Crestridge Drive, Silver Spring, MD 20910 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dysphagia /Medical Due to (or as a consequence of): Examiner Cerebral Vascular Accident Sequentially list conditions, frank and list conditions, frank and list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ertificate be executed burial-transit Due to (or as a consequence of): reing physician are as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death tten 23b. Was decedent pregnant 23d. Date of delivery that the death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) ☐Yes 2☐No ed by the detached P.O. signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Recurrent Infection, Aspiration Pneumonia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Advanced Age autopsy certificate 1 ☐ Yes 2K No 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral c 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel and manner stated. within 2 To the 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 December 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 03

2009

32 Registrar's Signat

8218 Wisconsin Avenue, #305, Bethesda, MD 20814

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12th10-2009 Nellie B. Smith 6:54 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 7816 Marker Road Middletown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 229-34-7246 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Frederick Middletown 1 🗆 Yes 2 🄀 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 7816 Marker Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Administration Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ျ Frank R. Bloxom Ella Lee Brumlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin J. Smith 7816 Marker Road Middletown, MD 21769 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-14-2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford P.A. F.H. M01176 106 East Church Street Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Chronis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ransit Examir Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> ARTELY CORONARY 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed ATRIAL FOBRILL ATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy OFYGEN 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 021944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOS# 8 MANATZIPI

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

7

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** R. Helen Swift November 20, 2009 0500 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pocomoke City Worcester Pat's Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕱 F 214-38-4639 101 09-18-1908 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 1XYes 2□No Directo MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Market Street 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ Specify. 3. Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Worker C & P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E.M. Smith May M.L. Lowe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Daum/grandson 6912 Hubbard Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Loudoun Park Cemetery 11/24/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22 Name and Address of Facility Hinman Funeral Home Signature of Funeral Septice Lice see M00295 11673 Somerset Ave. Princess Anne. MD 21853 Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nviedical Due to (or as a consequence Examiner ILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name a

Santiano,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

8th Street, Pocomoke City, MD 21851

nd address of person who completed cause of death (Item 23a) (Type, Print)

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			12/1//00	or Print in Bla of Maryland /		of Health	and Mental	Hygien	2009	40380
I	Physicia	an	1. Decedent's Name (First, Middle, Last)	CICK	Sloar	), Jr	2. Date of Month	. D	3 2009	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and The Johns Hopkins Hospital	number)	Baltim	own, or Location nore City				altimore
	Funeral Director		5. Social Security Number 214-46-3505 6. Sex 1 X M 2	7. Age (In yrs. last b	irthday) If Under 1 Yrs. Months	Year If Under Days Hours	r 24 Hrs. 8. Date o Min. (Mont)	f Birth n, Day, Year, une 01, 1	9. Birth Cou	place (State or Foreign ntry) Maryland
	Maryland -f show ed at	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Allegany	10c. City, Tox	wn or Location	Lona	coning			10d. Inside City Limits 1 Yes 2 □ No
	3a or 28a t be notifi	al Director	10e. Street and Number  2 Dudley St	reet	10f. Zip-C		539	10g. 0	Citizen of What Cou	ntry? JSA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Yes.	lecedent Ever in U.S. I Forces? es 2  No	13. Was Decede if Yes, specif	al.	rigin? (Specify Yes o nn, Puerto Rican, etc /:	r No- )	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	vithin 72 hou ine. than "natura e Medical E.	Completed by	15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12)  Colleg		a. Decedent's Usual (Give kind of work life. DO NOT use	k done during mo		16b.	Kind of Business/l	iversity
land 2	ild be filed v lental Hygie rked other t ic event, th	To Be Co	17. Father's Name (First, Middle, Last)	es Sloan			her's Name (First, M		den Surname) cella Allen	
$\leq$	1 and 2 shou Health and M tem 27 is mar		19a. Informant's Name/Relationship (Type. Print)  Molly Sloan - Daugh		9b. Mailing Address		ber or Rural Route N Street, Lonaco			
Baltimore,	Pages 1 and of the int: If item		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal fr. 4 □ Donation 5 □ Other (Specify)		of Disposition (Name tery, crematory or oth Cumberland C	her place)	Dec. 08, 200	er	Cumberla	rown, State nd, Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	holm		Address of Fac 8 East Ma	ain Street	Lonaco	-McKenzie F oning, MD 21	Funeral Home P.A 1539
	Physician		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition	at caused the death. Do in each line.	Λ	2	as cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
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50,	ificate be executed physician and as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.	e to (or as a consequence As)	piration	)		-		
). Box 6876	death cert e attending ed for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Vec 2 0 4 F	outcome of pregnancy ive birth 2 Fetal dearregnant at time of death			-		23d. Date of del Month	ive <b>ry</b> Day Year
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f Vita	Physician: The this certificate trail director, pa	To Be (	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital:	Inpatient 2 ER/	Outpatient 3 DO	Other:	ce of Death (Check of Nursing Home 5		6 ☐ Other (Spec	cify)
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (check only one) Certifying Physician: To Medical Examiner: On t and	the best of my knowled he basis of examination manner stated.	ige, death occurred and/or investigation,	at the time, date, in my opinion, o	and place, and due death occurred at the	time, dete	and place, and du	e to the cause(s)
	To the within 2 To the I	8	29b. Signature and title of certification, NID			ES-00			Date signed (Mont	3 2009
_	4	VA	30. Name and address of person who completed	SINGHE			600 North	Wolfe	St, Baltime	ore, MD, 21287
1	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC - 8 200	2. Pegistrar's Signature	pos	• 				

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Amended item 20b. per

Division of Vital Records, P.O. Box 68760,
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Examine	er	4a. Facility Name (If no WMHS Region	_				Cum	berl			A.	County of Dea	
Funeral Director		5. Social Security Numb	48	Sex 1 □ M 2 🛱 F	7. Age (In yrs. <b>79</b>		rs. If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, I Mar 11	irth Pay, Year) 19:		thplace (State or Foreign ountry) yland
Maryland I-f show	tor		cedent b. County <b>Garrett</b>			ity, Town	or Location						10d. Inside City Limits 1    Yes 2   No
th with the 23a or 28s	ral Director	10e. Street and Number 222 Grant	r		1020		10f. Zip	Code 215	36		10g. Citi	izen of What Co	buntry?
Irs a	by Funeral	11. Marital Status  1  Never Married  3  Widowed 4		Armed Fo	2 <b>⊠</b> No ve	J.S.	13. Was Deced If Yes, spec		spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
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and 2 shou lealth and M m 27 is mar her traumat	-	19a. Informant's Name							and Number or Re		ber, City o	or Town, State, .	Zip Code)
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Physician /Medical Examiner		23a. Part 1. Enter the d shock, or heart for Immediate Cause (Find disease or condition resulting in death)	flure. List onl	a. Meto	each line.  ***********************************	Squ quence of	iamous	Ce	11 car	cinon		Flung	Approximate Interval Between Onset and Death
executed in and ial-transit	ledical Examiner	Sequentially list conditi if any, leading to immed cause. Enter Underlyin Cause (Disease or Inju that initiated events resulting in death) Last	ons, diate ig ry	b. Pue to  c. He  Due to	or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the cons	quence of	Sec	on de	ary To	, Tur	nor		
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification: To	2 Accident 3 Suicide 6 4 Homicide	investigati Could not determine	be 28e. Place	of Injury - At h	ome, farn	n, street, factory		∕es 2⊡No	28f. Location City or To	(Street an own, State	nd Number or R	ural Route Number,
the Hospit nin 24 hour the Funera npletely fille	edical	one)	Medical Ex	Physiclan: To the aminer: On the b and man	e best of my kn- easis of examin ner stated.	owledge, ation and	or investigation	, in my op	oinion, death occu	e, and due to thurred at the time	e, date and	d place, and du	e to the cause(s)
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State of Maryland / Department of Health and Mental Hygien 2 0 0 9

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		•	1 - State Registrar		,	Cei	rtificate of	Death		Reg. No.	.000	40000
	Dhysisi		1. Decedent's Name (First, Middle	e, Last)					2. Date of De		Year	3. Time of Death
	Physici /Medic		Treva Palmer	Strickler					Dec.	3 Day	2009	9:10 A ^M
	Examir	er	4a. Facility Name (If not institutio	•	or)			r Location of Death		4c. (	County of Death	
-			49 E1k Hi11 C				E1kt		1		Cecil	
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	Director		165-05-0973 Usual Residence of Decedent		91	110.			Apr. 3	50, I	918 Pen	nsylvania
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	Mary f sh	ট	Delaware New	Castle	N.	ora Ca	astle					1 ☐ Yes 2 No
	the 28a	Director	10e. Street and Number	Castle	IN C	ew Ga	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	3a or		228 Gordy Pla	ce			19	720		U	SA	
	death ms 2	Funeral	11. Marital Status	12. Was Deceder		13.		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or N		4. Race - Americ	
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9	ral", c	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	31		1∐Yes 2∭XNo	Specify:			Specify: Wh	ite
2-0	within 72 hours after death with the Maryland lene. than "natural", or Items 23a or 28a-f show he Medical Examiter must be redified at	Completed	15. Deceden	t's Education st grade completed)	16	Sa. Dece	dent's Usual Occup	pation	dna	16b. Kin	d of Business/In	dustry
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n P	be fil ntal H id oth even	Be	17. Father's Name (First, Middle,					18. Mother's Nam		e, Maiden S	Surname)	
χ	ould Mer narke	၉	Charles Palme					Gertrude				
Jar	2 sh h and ris rr	1	19a. Informant's Name/Relations		11			and Number or Ru				Code)
a)	l and lealth em 27 ther t		Mark Strickle	r/Son	OOL Place			Court, E			1921	State
Ö	ges int of l		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from Stat	e Zob. Place ceme	tery, crer	sition (Name of natory or other plac	ce) 12-	Pate 12-09	200. Loc	cation - City or To	own, State
Ę	it. Pa rtmer rtant:		4 Donation 5 Other (S		Laure			ial Gard			mbia, P	A 17512
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examine Franch Let roffling at Once.		21. Signature of Funeral Service	see		22	R.T. Foar	ss of Facility d Funera	1 Home,	P.A.		
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Ć,	execi n and lal-tra	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequenc	e of):						
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68	tifical g phy as th	Medical										
Box	h cer endin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 D Fetal dea	a.F	∃Ectopic pregnanc			2	3d. Date of deliv	ery
	deal	sicie	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		at time of death		Other (specify)	y .			Month	Day Year
P.0	that the de ned by the a detached f	Physician										
Ś	ires tha signed d be det	þ	Part II. Other significant condition	ons contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did			he cause of death?
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<u> </u>	The ate h	Completed							perf 1 □ Yes	ormed? 2 No	death? 1 ☐ Yes	2 <b>,</b> ₩0
ita	iclan: The certificate ector, pag	Be (	25. Was case referred to medica examiner?	1				26. Place of Dea	th (Check only	one)		C
Ź	Physi this c a! dire		1 Yes 2 No		tient 2 ER/			4 LI Nursing H	ome 5 ☐ Res	idence 6	XOther (Speci	Son's Residence
<u>_</u>	Jing F	on:	27. Manner of Death  1 Natural 5 ☐ Pendir	28a. Date of Ir (Month, L	njury 28b Day, Year)	. Time of Injury	Wor		28d. Describe	how injury	occurred	
Sic	tend leath tor:	cat	2 Accident investing 3 Suicide 6 Could	not be				Yes 2 □ No				
Division of Vital Records,	or Attendate death	Certification: To	4 ☐ Homicide determ	ined   20e. Place of I	etc. (Specify)	tarm, str	eet, factory, office		City or To	(Street and wn, State)	d Number or Hun	al Route Number,
	Hospital 24 hours Funeral stely filled		29a. Certifier 1 Certifvii	ng Physician: To the be	st of my knowled	lge, deat	h occurred at the ti	me, date and place	and due to the	e cause(s)	and manner as	stated.
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination	and/or in	vestigation, in my o	opinion, death occu	rred at the time	, date and	place, and due t	o the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	M	29b. Signature and live of certifie			Im	29c. Licens	e number	( =	29d. Date	e signed (Month,	Day, Year)
			()/-	=>>	-	7	1	0056	449	12	2/3/	99
			30. Name and address of serson	who completed cause o	f death (Item 23a	a) (Type,	Print) / /	01	1	- 1	7	-11/4 1110
		(		nonsan	moll	LOU	1. Hzzl	n otre	et du	uto	,502 t	THE TON IN
	Sta Registr	_	31. Date filed (Month, Day, Year)		strar's Signature		) '					01701

# Baltimore, Maryland 21215-0036

Box 68760 P.0. of Vital Records,

Division

1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Katina C. Singleton 1900 Nov 23 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105 Foxfield Apts. #1-A Salisbury Wicomico 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1□M 2√F May 7, 48 Director 1961 MD <u>219-60-2334</u> Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ty∑Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Foxfield Apts. #1-A 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 ☐ Never Married 2 Married Specify: African-1 □Yes 2 No <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Brown, Jr. ပ Martha Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. Terrence Brown/brother 27793 Ocean Gateway, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Acres 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2009 Salisbury, MD Memorial_Park 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 21. Signature of Euneral Service Licensee 1618 West Road, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 MNo 1 ☐ Yes 2 ☐ No 1 □Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1⊠Yes 2□No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending I 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) DME 11/25/09 4-5049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801 100 Ecarroll myder 0.0. hris 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

40383

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

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			For State Registrar	State of Ma	arylari	•	rtificate o		іментат пу	gierie Reg. No	0000	1.0385
			Decedent's Name (First, Middle, Las	1)					2. Date of De			3. Time of Death
- 100	Physici /Medi		May Louise Sollit						Novembe	er 28	8, 2009	8:05 A ^M
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and app.	Funeral		Shady Grove Advention 5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6.	7. Ag		last birthday)	Rockvil If Under 1 Yea	r   If Under 24 Hrs		th .	ontgomen	rthplace (State or Foreign
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Marylan a-f show	tor	Maryland Montgome:	rv	Dick	erson						1 □Yes 2 XNo
	or 28k	Director	10e. Street and Number	Ly	DICK	CISON	10f. Zip Code	•		10g. Ci	tizen of What Co	ountry?
	s 23a		25101 Old Hundred			- 17 ·	20842			USA		
10	fter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅		S. 13.	Vas Decedent of f Yes, specify Co	f Hispanic Origin? (8 uban, Mexican, Puer	Specify Yes or No to Rican, etc.)	0-	14. Race - Am Black, Whit	
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5-0	filed within 72 hours after death with the Maryland Hygiene Wher than "natural", or items 23a or 28a-f show ant, the Medical Evarinas ruest be notified at	Completed by	15. Decedent's Edi (Specify only highest grad	ucation de completed)	- 4	(Give	lent's Usual Occ kind of work don	e during most of wo	rking	16b. k	(ind of Business	/Industry
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Maryland 21215-0036	she and sum tum		19a. Informant's Name/Relationship (7					et and Number or R				•
ď	of Health of Health item 27 i		Robert F. Sollitte	o, III, se			Cook B sition (Name of natory or other p	orthers R	Date		ille, MI .ocation - City or	
Ē	Pages ent of nt: If if		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					12/	3/2009		•	
Baltimore,	permit. Pages 1 Depertment of P Important: If ite any injury or of once.		21. Signature of Funeral Service Licens		пуа	LLSLOW 22	. Name and Add	list Cemet   Cemetar   C	lesworth	<u>нуа</u> n-Wi	ttstown 11iams 1	, Maryland Funeral Home
<u> </u>	9 9 E 8 9		yau h.	Ders		26	401 Rid	ge Road,	Damascus	s, Ma	aryland	20872
			23a. Part 1. Exter the disease, or comp shock, ir heart failure. List only of	lications that second second in	the deathne.	h. Do not ent	er the mode of d	ying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consegu	uence off:						
	sician buria	ਲ		Duc to (or as	a consequ	derice oi).						
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30X	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ncv			23d. Date of de	
0	at the dea by the at tached fo	ysici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	leath 5	Other (specify)				Month	Day Year
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of Vital Records,	w requires been sign should be	Completed by	Coronary Artery	Disease, I	lyper	tensio	n, Pulm	onary	10	Yes 2	!□No 3□F	Probably 4 🕅 Unknown
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<u>=</u>	lan: The I rtificate ha tor, page :	S							perfo 1 □ Yes	ormed? 2 X No	death?	
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		n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of	1 3 DOA	4 🗀 Nursing r	Home 5 ☐ Resi 28d. Describe			ecify)
io	ending l ath. or: After ne funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, rear)	Injury		ork? □Yes 2□No				
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specif	me, farm, str	eet, factory, office	•	28f. Location ( City or To	Street a wn, Stat	nd Number or Fi e)	Rural Route Number,
	Hospital or Attending 24 hours after death. Funeral Director: Afte ttely filled in by the fune		29a. Certifier 1 X Certifying Phy	rsician: To the hest	of my kno	wledge deat	occurred at the	time date and place	e and due to the	causel	s) and manner s	as stated
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	Sta	ite	Nicole Vetere, MD 31. Date filed (Month, Day, Year)	32. Regist	uica. ar's Signa	ture	er Drive	, Kockvil	ie, Mar	yLan	.d 2085	0
	Registr		DEC 01	2009	wasterd.	o fil.	park					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	-	1 - State Registrar Certificate of Death Reg. No.							40000	,			
Dhuaisia		1. Decedent's Name (First, Midd			2.				2. Date of Death Month Day Year 3. Time of Death				_
Physicia /Medica	_	Claudia Ann	Smallwood				November	. Ž4,	2009	10:35 p ^M			
Examine		4a. Facility Name (If not institution	4b. City, Town, or		Death			nty of Death					
		Casey House Mo		Rockvil		4 Uro 1	0.00		ntgome		_		
Funeral Director		5. Social Security Number 130–30–7949	6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. las 68	t birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day, Jun 15,	^{Year)} 1941	Cour	place (State or Foreign ntry) sylvania	
M	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits	-
8a-f sho	Director	Maryland Fre		mmits	burg				1 X Yes 2 □ No				
23a or 2 ust be n	ral Dir	10e. Street and Number 401 W Lincoln	10f. Zip Code	21727				of What Cour JSA	ntry?				
0,1	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	Armed For	e	1	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes 2 No Specify:					14. Race - American Indian, Black, White, etc.  Specify: White		
ne. han "natt «Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12  In the content's Education (Give kind of work done during most of working life. DO NOT use retired)  Waitress  Restau									·		
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Departi Import any Inj once.		21. Signature of Funeral Service	Licensee	rou	22	Name and Addres	s of Facility	Mye Emmi	ers-Durbo tsburg,	oraw E MD 21	Tunera   727	1 Home	
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signed b	þ	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.											
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atter deatl  Director: I in by the	Certification:	2 Accident investigation   M   1 Yes   3 Suicide   4 Homicide   4 Homicide   4 See   4							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
e Funeral	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										-	
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5		30. Name and address of person	extensu, A	1D. 60	OI N	Print) Jungaster	MILL	Roa	id, Roc	KVILLE	., Md	. 20855	
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40387 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:35 PM November 2009 TULL MARTHA М. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner McCready Memorial Hospital Crisfield Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 TF 80 218-24-4942 Director July 6, 1929 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Somerset Crisfield 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21817 26466 Old State Road U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Iter any Injury or other traumatic event. the Medical Fyamina 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Worker MD Veterans Commission 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlton Marshall Ethlyn Laird 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Smith Street - Cambridge, Stephen Tull (Son) MD21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 11/28/09 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 21. Signature of Thera Service License

Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 x Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 HALL HIGHWAY, CRISFIELD, KARUMBUNATHAN MAZIY

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🗋 🗎 🥄 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 315 P.M Marvin 2009 VOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburg Solisbury Rehabilitation + Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wicomico 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 M 2 □ F Days Hours 217-30-9534 **Director** 1-18-33 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In propriant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once. 1 ¥Yes 2 No Directo ristield Mary land Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211817 93 U.S. A. Somars Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Syres 2 □ No If Yes, Give Year or Dates: j 454 - [974] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married | homas | / lのい Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States (Specialist 4 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Willams Rebecca ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Aristodrat A. Thomas -Nephew Lane Fayetteville N.C. 28306 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury 11117/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anthony E. Ward Funeral Home Signature of Funeral Service Licensee 30639 Hampden Ave, Princess Anne, md 23a. Part1. Enter the disease, or complications that caused the death. Do, ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) can a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. The underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and ached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2 ☐No g 🔲 Unknown q | Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sal director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 11 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in 24 hour.
the Funeral Directory filled in by the 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal within 2 To the I and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Salisburu William H. Robins 200 m. D State NOV 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Rea. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month 515 A M **Physician** December 2 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NONE The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 SM 2 F 7/17/1929 Hong Kong Director 80 363 34 4378 Usual Residence of Decedent with the Maryland or 28a-f show notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City 1 Yes 2X No Director MD Howard 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country ral", or items 23a o Examiner must be 21042 TISA Funeral 9039 Furrow Ave. Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Asian 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry th and Mental Hygiene.

?? is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (14 or 5+) Elementary/Secondary (0-12) Education Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amy Hoh Paul S.F. Ts'o ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9039 Furrow Ave., Ellicott City, MD 21042 Health a Muriel Ts'o / Wife Department of Health Important: If item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/06/2009 | Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 21. Signatur, f Pineral Service Icensee 22. Name and Address of FacilityHarry H. Witzke's Family FH, Inc. M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** intraceve brail hemorrhung disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Drain Nervication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the at d be detached f 2 🗌 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မ s after dec... 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation njury 2 Accident 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Kevin Gibbs 600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 4 2009

32. Degistrar's Signature

Since S. Sparks

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Daimian Kinte T	•	ton, Sr. St I- For State Registrar	ate of Maryland	•		f Health <i>f Death</i>	and Men	tal Hygi		g. No. 2	00	9 4039
Physicia	an/	Decedent's Name (First, Midd	le,Last)						Date of Death	Day Ye	ear	3. Time of Death
Medical Exami			Kinte! Tho					١	lovember	28, 2009		2330 hrs
		4a. Facility Name (if not institution Route 13 at Crown Route 1	-	-)		4b. City, Town		of Death		4c. County Wicom		
F		5. Social Security Number		ge (In yrs. last	hirthday)	If Under 1		er 24Hrs. 8	Date of Birt			hplace (State or
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MI and 2 s salth a em 27	1	Lorenzo & Glori  20a. Method of Disposition	a Beach/ pa			Whitet sition (Name o			ardela ate	Springs 20c. Location		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers important. If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Crematio	n 3 Removal from S		matory or o		.,			ļ	•	
tim t. Pag timent ritants		4 Donation 5 Other S 27. Signature of Funeral Service		John	Wesl	ev_C(	Cem.					Marylandsbury, MD
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trai	ical	UNPENDED	dAMENDED			-						
760, icate be exe	Med	IF FEMALE:	23c. If yes, outc	ome of pregna	ncy					23d. Date	of deliver	<u>,                                     </u>
687 certific iding 1	ian/	23b. Was decedent pregnant in t past 12 months?	Live blid!	at time of death	L - =	etal death		ic pregnanc	у	Month	I	Day Year
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  **All Director** After this certificate has been signed by led in by the funeral director, page 2 should be detach	ü	27. Manner of Death  1 Natural 5 Per	28a. Date of Ir (Month, Day Nov 28, 200	njury 2 (Year) 09 (	28b. Time of 2000 hrs		Injury at Wor	_ ID:		how injury occ fixed object		on
Siol Atten r death ector; by the	Certification:	o rei	estigation		ne form etr				Rf Location (	Street and Nu	mher or Ri	ral Route Number City
Divi al or s after al Dir	if.	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 13 at Crown Road, Fruitland, Md										
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I		4 Homicide  29a. Certifier (Check only)  1 Certifying F					ne, date and p					-
To the Hos within 24 h To the Fur	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
F 3 F 3	Re	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)		
	\	Momente On	e Ghell.				D.C.M.E.			Novemb	er 29, 2	009
Hell		30. Name and address of perso	· ·						004			
v		Margarita Korell MD.	Assistant Medica			Penn Stree	t, Baltimor	e, MD 21	201			
S Regis	tate trar	31. Date filed (Month, Day, Year	1 2009 Ser	rar's Signature	9. 40	arke						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day ANTREA TOWNSEND 2:00P M NOVEMBER 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Country) Jamaica 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☐ M 2 🔯 F Months Days Hours Min. JAN.30, 1964Director 086-80-5422 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 12420 Beachley Drive 21740 Jamaica items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 'natural", or þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 X Divorced Completed Jamaican 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5 +Teacher County School System injury or other traumatic event, Be Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Osbourne W. Townsend Amy Elizabeth Furguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 2108 Chestnut Lane / Frederick, Maryland 21702 Candace Allen / Sister Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Stauffer Crematory 12/02/2009 Frederick, Maryland permit. 21. Signature of Funeral Service Lie 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Prier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ brain disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or linjury that initiated events that the death certificate be executed resulting in death) Last physician s the burial Physician/Medical Box 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death Unknown sate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 Yes 2 No Yes 25. Was case referred to medical æ director 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Inpatient ျ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify eral Director: After th filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No after death Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) thin 24 hours a the Funeral C To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24

To the F

complet 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 200 D 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th St./ Frederick, Maryland 21701 Myung H. Nam

State Registrar 31. Date filed (Month, Day,

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael John Verdi November 30. 2009 1720 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 29, 1916 228-10-2111 1 **∑** M 2 □ F Months Hours Director 93 Virginia Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Havre de Grace Maryland Harford 1 X Yes 2 No 10e. Street and Number 23a or 2 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21078 100 Revolution Street, Apt. 106 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black White, etc. 1 Never Married 2 Married δ "natural", or 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced or Dates. 1941-45 Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry V.A. Medical Center (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Two Years Elementary/Seconday (0-12) Payroll Department Perry Point, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (maiden name unknown) Maria Nicholas Verdi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Sharon Elliott (daughter) 810 Giles Street, Havre de Grace, Maryland 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Havre de Grace, 12/03/09 4 Donation 5 Other (Specify) Erin Cemetery Maryland 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami and -transit Due to (or as a consequence of): sician a burial-t resulting in death) Last Physician/Medical requires that the death certificate be Records, P.O. Box 68760 phys. attending pl IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending injury 2 Accident Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co Trond 5+WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 8 2009 12:50 AM **Physician** Vega-/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and humber) Examiner Montgomeri KVI II C Home Nursing Potomae alley 7. Age (In yrs. last birthday) 65 Yrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June4, 1944 Social Security Number Days Months Hours Salinas, 1**X** M 2□ F 581-86-1475 Rico Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Prince George's Bowie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20720 7027 Highbridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 XYes 2 No Specify: Puerto Rican Specify: þ 3 Widowed 4 Nivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Transportation Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Felicita Lopez Ramos Francisco Vega DeAlma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7027 Highbridge Road Bowie, Maryland 20720 Norberta Ramos -sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Cementerio Municipal 12/14/2009 Salinas, Puerto Rico 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Long Tor V. dor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular 5 days Due to (or as a consequence of) 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Year Month in the past 12 months? Dav 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Funeral** 

Director

isen 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercites must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercit

Baltimore, Maryland 21215-0036

death

attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760. ed by the a

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p

24a. Was an

26. Place of Death (Check only one)

Thrive

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? examiner?
1 Yes 2 No

5 Pending

investigation

27. Manney of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Tyes

28d. Describe how injury occurred

6 ☐ Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature in thirty of certifier

thyrus, CRNP

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) Molecular Drive #201 Rockville 20 10110 MARY

State Registrar

Medicai Certification: To

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien n n n Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year  $P^{M}$ 27, 2009 4:40 June C. Whitacre November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Collingswood Nursing Home Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 14, 1930

9. Birthplace (State or Forei Country)
West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🖾 F 79 Yrs. 233-42-8186 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 X Yes 2 No Maryland | Montgomery **Burtonsville** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3001 Winifred Drive 20866 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3₺ Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cardone Mary Hendrickson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry J. Whitacre/Son 510 Acorn Court; Mount Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 12/4/09 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the diseas shock, or heart failure Immediate Care (Final disease or condition or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. disease or con itio resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

marked other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760

Division or Vital

72

Director

Funeral

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Completed

Be

attending physician for use as the buria as nse ed by the signed to

Examine Physician/Medical \$ Completed page 2 completely filled in by the funeral director, Be ၉

certificate

After this

death. after death

within 24 hours a To the Funeral C

Hospital or Attending

To the

Certification:

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖫 No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29a. Certifier

29c. License number D0062435 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mole Colar Dr. Rockville, Mi) 20850 EISAYYAID 0110 31. Date filed (Month, Day, Year)

State Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 4, **Physician** 2009 Whetzel R. Robert 10:40am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12033 Kite Avenue Cumberland Allegany Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 8, 1927 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F 216-22-7178 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens III at them 23s or 28s-f show any injury or other traumatic event, Inc Medical Eventual, or items 23s or 28s-f show any injury or other traumatic event, Inc Medical Eventual to the reduced once. MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12033 Kite Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No ģ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) factory worker Kelly Springfield Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel John Whetzel Myrtle Victoria (Wigfield) Whetzel ٩ 19a. Informant's Name/Relationship (Type. Print)
K. June Whetzel (Street and Number or Rural Route Number, City or Town, State, Zip Code) ์MัDั 21502 12033 Kite Avenue wife Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 12/7/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Juneral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardismoscula at he nosclest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Disk to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 Z No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, 24 hours a completely within 2 To the I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

VIKRAMADIT 31. Date filed (Month, Day, Year)
DEC 17 2009 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

D36766

24 SETON I

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30, June Groves Walker 2009 November 2:53 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Dec 31 9. Birthplace (State or Foreign Country) Delaware 6 Sex Year 1918 Min. Months Days Hours 1 □ M 2 🖾 F 222-03-3941 90 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 € No Maryland Montgomery Laytonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22501 Robin Court 20882 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ➡No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 4 School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Groves Louise Winkler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Walker Bridgett/Daughter 22501 Robin Court, Laytonsville, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 7, 2009 Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 21. Signature of uneral Service Licens 22. Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUTE -E17 E15 MIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTI 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 1 No 1 ☐ Yes 2 No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

d other than "natural", or items event, the Medical Exeminer or

7 is marked other traumatic event.

permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.

Examiner Physician/Medical

physician and the burial-tran attending p certificate has been signed by the rector, page 2 should be detached <u>۾</u> Completed 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director. Be Medical Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

1 □Yes 2 ĀNo 9 □ Unknown	9 Unknown	5 🗆 Other (specify)
Part II Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part

examiner? 1 ☐ Yes 2 ☑ No	
27. Manner of Death	 -

5 Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

PLOCKVILLE.

29a, Certifier

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Whethe

10051158

29c. License number

DRIVE

29d. Date signed (Month, Day, Year) 2009 DECEMBEN

MO20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTHOM 31. Date filed (Month, Day, Year)

DEC 03

2. Registrar's Signature

VEINS

701

State Registrar

DHMH 17 Rev 1/2001

To the Hosp within 24 hou To the Fune completely fi

20

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dhysisian	
Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinat Laurettial at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

2

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the Attenting physician and completely filled in by the funeral director, page 2 should be detached for uce as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Olate	or ivial yla		ertificate				Reg. No		09	400	397
1. Decedent's Name	e (First, Midd	e, Last)						2. Date of De Month	ath Da	av.	Year	3. Time of	Death
John Rus	ssell V	Mite						Decemb			2009	6:45	P M
4a. Facility Name (I	If not institutio	n, give street and no	ımber)			_	tion of Death				y of Death		
Garrett 5. Social Security N	County	Memorial	Hospi 7. Age (In yr	tal	Oakla		nder 24 Hrs.	9 Date of Bir		Garr		place (State o	r Foreign
218-64-76	687	1 M 2 □ F	54	Yrs.	Months [		urs Min.	8. Date of Bir (Month, Da 4/9/19	y, Year) 55	)		place <i>(Stat</i> e o ntry) 1and	r roreign
Usual Residence of 10a. State	10b. County		10c. C	City, Town or L	Location							10d. Inside Cit	ty Limits
MD	Common	- 4-	0.01	l am d								1 ☐ Yes	2 No
MD 10e. Street and Nur	Garret mber	<u>. L</u>	Uak	land_	10f. Zip C	ode			10g. Ci	tizen of	What Cou	ntry?	177
1355 Bet	thlehar	n Road			2155	50			Unit	ted	State	28	
11. Marital Status		12. Was Dec	edent Ever in l	U.S. 13	If Yes, specify	nt of Hispani	ic Origin? (Spe	ecify Yes or No	)-		ce - Ameri	can Indian,	
1 ☐ Never Marri 3 ☐ Widowed		ried 1 ☐Yes	2 🔽 No		1 □Yes 25		ecify:	Tilodii, otoly			fy: White		
-	cify only highe	t's Education st grade completed)	_	16a. Dec (Giv life.	edent's Usual ( re kind of work DO NOT use	Occupation done during retired)	most of worki	ing	16b. K	(ind of E	Business/In	dustry	
Elementary/Second 1.2	ndary (0-12)	College (	1-4or 5+)		Mason				Cons	stru	ction	1	
17. Father's Name (	(First, Middle,	Last)				_		e (First, Middle,					
Calvin Wh	hite					Dor	othy L	illian	Bums	s Wh	ite		
19a. Informant's Na Connie Wh					ling Address (S Bethle							Code)	
20a. Method of Disp 1X Burial 2 D 4 Donation	Cremation	3 ☐ Removal from	State	cemetery, cre	position (Name ematory or othe rk Ceme	er place)		2/2009			- City or To		
21. Signature of Fu			1 2		22. Name and								
Kat	neixe	> Vivei	Ther		1 N. Se							al Hou	ie
23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition	rt failure. List (Final	complications that only one cause on	aused the dea								.1330	Approximate Interval Bety Onset and D	veen
resulting in death)	uri	Due to	(or as a conse	quence 1):	1921	CCO	1000	Carri				70	
Sequentially list con if any landing to imi cause. Enter Under Cause (Disease or	nditions,	b. Due to	(or as a conse	quence of									
triat initiated events		с											
resulting in death) L	_ast	Due to	(or as a conse	quence of):									
		d											
IF FEMALE: 23b. Was decedent in the past 12 □ 1 □ Yes 2 □ 9 □ Unknown	months?	1 Live	tcome of pregr birth 2  Fet lnant at time of nown	tal death 3	☐ Ectopic pred						ate of deliv	-	ear
Part II. Other signifi	icant condition	ons contributing to d	eath but not re	sulting in the	underlying cau	se given in F	Part I.	23e. Did t	obacco	use con	tribute to t	he cause of d	eath?
								10	Yes 2	□ No	3∏ Proi	bably 411	Inknown
								24a. Was autor perfo	osy rmed?_		prior to co death?	opsy findings a	available ause of
25. Was case referr	red to medical					26 1	Place of Death	1 ☐ Yes		)	1 ☐ Yes	2 □No	
examiner? 1 ☐ Yes 2 ☐	10	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Other:		me 5 ☐ Resid		6 □ Ot	her <i>(Speci</i>	fy)	
27. Manner of Death  1. Natural 2 Accident	h 5  Pendin investig	9 .	of Injury th, Day, Year)	28b. Time Injury	of 28c	. Injury at Work? 1 □ Yes		28d. Describe I				<i>,</i> ,	
3 ☐ Suicide 4 ☐ Homicide	6 Could a determ	ined 28e. Place	of Injury - At I ing, etc. <i>(Sp</i> ec	nome, farm, s hify)	treet, factory, o	ffice	:	28f. Location (S City or Tov	Street ar vn, State	nd Num e)	ber or Run	al Route Numi	ber,
29a. Certifier (Check only one)	1 ☐ Certifyir 2 ☐ Medical	g Physician: To the Examiner: On the b and man	e best of my kr pasis of examinate	owledge, dea	ath occurred at investigation, ir	the time, da	ite and place, , death occurr	and due to the red at the time,	cause(s	s) and n d place,	nanner as a	stated. o the cause(s)	
29b. Signature and t	title of certifie	0			29c. L	icense num			29d. Da	te signe	ed (Month,	Day, Year)	
•	til	olm				DIS	333	3	(	121	11/6	17	
30. Name and address						d. MD	21550					1	
31. Date filed (Month			Registrar's Sign	ature	. 4		21770						
	DEC	11 2009	Bus	a B	! Soor								

State

Registrar

10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 2009 Davidsville, PA Approximate Interval Between Onset and Death Physician/Medical signed by the attending physician be detached for use as the burial The law requires that the death certificate be Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? þ σ. Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other, Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Natural Yes 2 XNo unk Pending within 24 hours after death.

To the Funeral Director: Fd12/8/09 Fd 4:00 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1228 Hoyes Sang Run Friendsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined house (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 9, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registra

DOME

1634 hrs

Box 68760 o О. Division of Vital Records,

Baltimore, Maryland 21215-0036

For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 07, 2009 Agatha Warnick 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Egle Nursing and Rehab Center Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 X F Maryland 212-74-0940 May 19, 1916 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 ☐ Yes 2 No Frostburg Maryland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21532 Items 23a 15800 Warnick Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 No Specify: ģ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Weimer Gilbert Colmer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13605 New Georges Creek Road S.W., Frostburg, Maryland, 21532 Michael Warnick - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Avilton, Maryland St. Anne's Cemetery 15, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 8 East Main Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a gons a uence of): disease or condition resulting in death) /Medical **Examiner** Can drivery o pulm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Doath 28b. Time of 1 Natural
2 Accident 5 Pending investigation 1 Tyes 2 🗌 No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 126907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 925 Bishop Walsh Road, Cumberland, Mary land 21502 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		For State Registrar	ricase	State of Ma		d / Depa		t of H	ealth a		tal Hyg		_	4040	0
		1. Decedent's Name	e (First, Middle, La	ist)						2. [	ate of Deat			3. Time of Deat	th.
Physici		Myrtle	Louise V	Winstead							Month SVembe	Day	3, 2009	10:05P	, М
/Medic Examin				ve street and number)			4b. City, 1	Town, or	Location of		, v Canabo		County of Deat		
<i>)</i>		9132 Alb	augh Road	£			New W	inds	or			Fre	ederick		
Funeral		5. Social Security N	lumber 6. 8	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. 8. D	ate of Birth	Year)	9. Birt	hplace (State or For untry)	eign
Director		577-48-6 Usual Residence of	1462 f Decedent	1□м ЖД F		4 Yrs.				Aug	Month, Day,	915	Ohi	0	
arylar show	-	10a. State	10b. County			, Town or Lo								10d. Inside City Lin	
Ba-f	ecto	MD	Frederic	ck 	New	Windso								1 □ Yes 2 🔀	INO
vith th	Funeral Director	10e. Street and Nur		3			10f. Zip					_	en of What Co	untry?	
sath v	eral		augh Road	T	Francia II C	12	217		i- Oriei	i=2 (C===if+)		ISA	4 Dans Assa	olean to all an	
ter de	늘	11. Marital Status	ied 2□ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔼		), 13.	If Yes, speci	ify Cubar	, Mexican,	in? (Specify Puerto Ricar	n, etc.)	'	4. Race - Ame Black, White	e, etc.	
irs af	b	3 Widowed		If Yes, Give Year or Dates:	•		1 □Yes 2	No 🄀	Specify:		Specif			içan rican	
2 hou	ted	-	15. Decedent's E	ducation		16a. Dece	dent's Usua	I Occupa	tion		- 1		d of Business/		
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d wit	Completed			4		Teacl	ner					Educ	cation		
e file tal Hy d oth	Be (	17. Father's Name		)				- 1		's Name (Firs		1aiden S	Surname)		
buld by Meni	ဥ	George T							Lotti	.e Brov	vn				
2 sho n and is m raum		19a. Informant's Na					-					-	Town, State, 2	Zip Code)	
and dealth m 27			ohnson/da	aughter	Jan. 51							<u>.                                    </u>	1 45237		
ges 1 It of F If ite or ot		20a. Method of Disp 1 ☐ Burial 2 [		Removal from State			osition (Nam matory or cti			Date	- 1		ation - City or		
t. Pa rtmer rtant: njury	- 35		5 ☐ Other (Special		Fin								oine, M		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event, If a New Collect Examination to other traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event e		21. Signature of Fu	uneral Service Lice	nsee									P.O. Bo		
		23a Part 1 Enter ti	be disease or com	polications that caused									cksvill	e, MD 210 Approximate	29
3 6		shock, or hea		plications that caused one cause on each li				or dynng	, such as G	ardiac or res	piratory arre	351,		Interval Between Onset and Death	
Physician // /Medical		disease or condition resulting in death)	on a	a. End Sta	-		ancer								
Examiner				Due to (or as Anemia	a conseque	ence or):									
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leath certificate attending physi I for use as the b	sician/Med	23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth	2 - Fetal	death 3	☐ Ectopic pr					23	3d. Date of del Month	ivery Day Year	
ne de the a	sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	ŽNo	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (spe	ecify)					WOTH	Day Teal	
The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Phy			contributing to death b	ut not recui	ting in the u	ınderlyina ca	use dive	n in Part I	11.	23a Did toh	acco ne	e contribute to	the cause of death?	2
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e faw has l	mp										24a. Was ar autops	v I	prior to	topsy findings availa completion of cause	able of
n: Th licate r, pag	O.										perform I∐Yes 2	No	death? 1 □ Yes	2 🗆 No	
sician: The law s certificate has b irector, page 2 s	Be	25. Was case reference examiner?		Hospital:	- = -			Other		of Death (Ch					
Physical di	5.	1 ☐ Yes 2 🔀 27. Manner of Deatl		1 ∐ Inpatie 28a. Date of Inju		R/Outpatie	nt 3 □ DO/	A Bc. Injury	4 L Nurs		5 AReside Describe ho		Other (Spe	cify)	
ding th. : Afte : fune	tion	1 XNatural 2 ☐ Accident	5 Pending investigation	(Month, Da	y, Year)	Injury	M	Work?	es 2 □ No		Describe no	w injury	occurred		
Atten r deal	ţica	3 🗌 Suicide	6 Could not b		ury - At họn	ne, farm, str				-	ocation (St	reet and	Number or Ru	ıral Route Number,	_
all or safter	Certification:	4 Homicide	determined	building, et	c. (Specify)	)					City or Town	, State)			
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, is	Medical C	29a. Certifier (Check only one)	1 X Certifying Pl 2  Medical Exam	nysician: To the best miner: On the basis o and manner sta	f examinati	/ledge, deat on and/or ir	th occurred anvestigation,	at the tim in my op	e, date and inion, death	l place, and on occurred at	due to the ca the time, da	ause(s) a ate and p	and manner as place, and due	s stated. to the cause(s)	
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vei To Co	2	29b. Signature and	title of certifier	Reill	41	mD		License 5474					signed (Monta		
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State Registrar 31. Date filed (Month, Day, Year) DEC 0 2 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death B. Time of Peath Month Physician/ 5:30 A M 2009 BELINDA WALTERS November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 12, 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 203-44-0900 54 Pennsylvania Director Apr Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick 1 XYes 2 ☐ No Frederick 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be 10g. Citizen of What Country? Funeral 6411 Mercantile Drive East #004 21703 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African If Yes, Give Year or Dates 3 Widowed 4 Divorced Americar 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other t 12 <u>Homemaker</u> Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel Holloway Ruthie Mae Williams permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Walters/husband 6411 Mercantile Dr. East #004 Frederick, MD 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 11/28/09 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licer Golffa Moffess Crestation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and eath Immediate Cause (Final Lun can (w Physician/ Medical resulting in death) Due to (or as a sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that leithed as or linjury Due to (or as a consequence on Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) Month Day Year Pregnant at time of death n signed by the a Id be detached f 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 🌠 Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy performed this certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Accident 1 Tes Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital A hours a er dee...
---ral Director Afferhatte the Funeral Directory and filled in by the within 24 ho

To the Fune

completed 1

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature 29c. License number Doob 222 3 ss of person who completed cause of death (Item 23a) (Type, Print)

OREN BOLANN, HO 19675 DUVE, FREIENICE, MO 21702 32. Registrar's Signature

1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

3altimore, Maryland 21215-0036

within 24 hours after deatl To the Funeral Director; ò filled in Hospital completely

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State Registrar

27, Manner of Death

1 🛚 Natural

2 Accident

4 🗌 Homicide

(Check only one)

29b. Signature and title of cert

3 T Suicide

29a. Certifier

5 Pending

2 Medical E

investigation

6 Could not be determined

Sirak Hagos Lemma, 1500 Forest Glen Road, Silver Spring, MD 20910 MD 31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

Aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D65069

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

November 30, 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dennis Nusbaum Yingling November 25, 4:30 p 2009 /Medical 4a. Facility Name (If not institution, give street and number) Diven 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village House Carroll Westminster if Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 212-09-1025 Director 95 Feb 17, 1914 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shover the Wedical Evaniner must be notified at 1XYes 2 □ No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 250 St. Luke Circle, apt 713 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWI] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WWII Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Man Banking Bank President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Nusbaum C. Tobias Yingling 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once. Patricia Y. Shipley, daughter 134 West Church St, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/01/2009 Pleasant Valley Cem Westminster, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 تمد 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🗆 No 25. Was case referre medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 435 15 FED LIV 1∐ Yes₁ 2 🗷 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the nospinal within 24 hours after death.

To the Funeral Director: A really filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ANESTO 31. Date filed (Month, Day, Year)

NOV 30

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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Jailles	Homas	TOTASTILE

Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland  Department of Health and Mental Hygiene.  Introduce I in marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 Married 3 X Widowed 4 Divorced If Yes, 15. Decedent's Education (Specify only high Elementary/Secondary (0-12) 12th  17. Father's Name (First, Middle, Last) Hillary Yorkshire  19a. Informant's Name/Relationship (Type, Property of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content o	7. Age (In yrs. last bit 85  10c. City, Town Mecha  Ner Road  Vas Decedent Ever in U.S. rmed Forces?  Yes 2 No Give Year 948 – 1949 est grade completed)  loblege (1-4 or 5+)	4b. City, Town, or Mechanics' Mechanics' Months Day Months Day 1 or Location    nor Location    nor Location    10f. Zip Code	Location of Death ville  If Under 24Hrs.  Hours Min.  Min.  5 9  spanic Origin? (Specn, Mexican, Puerto Rice)  specify:	04/19,	4c. County of Death St. Mary's  MM/DD/YYYY) 9. Bir Foreig Cc  Citizen of What Cou	thplace (State or gn puntry) MD  10d. Inside City Limits	
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the N permit. Pages I and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be notified.  To Be Completed by Funeral Dir	11. Marital Status 1 Never Married 2 Married 3 Never Married 2 Married 3 Never Married 2 Married 3 Never Married 2 Married 15. Decedent's Education (Specify only high Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Hillary Yorkshire 19a. Informant's Name/Relationship (Type, Property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the pr	Vas Decedent Ever in U.S.  rmed Forces?  Yes 2 No  Give Year 9 48 - 1 9 4 9  est grade completed)  ollege (1-4 or 5+)	206  13. Was Decedent of Hi If Yes, specify Cuba  1 Yes 2 No Decedent's Usual Occupa	spanic Origin? (Specin, Mexican, Puerto Ri	cify Yes or No-	J.S.A		
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Physician /Medical zaminer			phalt Work	18.Mother's Name (F Mary Vi	irst, Middle, Mai	,		
Physician /Medical 'xaminer	Peggy Yorkshire-H	rint )	9b. Mailing Address (Stre	et and Number or Ru	ral Route Numbe	r, City or Town, State	∍, Zip Code)	
Physician /Medical zaminer	20a. Method of Disposition  1	moval from State Cham	Gardens	al   12/	4/09 L	oc. Location - City of eonardto	wn,MD	
/Medical - - - - - - - - - - - - - - - - - - -	21. Signature of Funeral Service Licensee		22. Name and Addres 12294 Old	Washing	ton Rd.	Waldor	f.MD. 20	
ner		is that caused the death. Do received:  ple Injuries  (or as a consequence of):	not enter the mode or dying	, such as cardiac or r	espiratory arrest,	snock, or near	Approximate Interv Between Onset an Death	
E E	cause. Enter Underlying Cause	(or as a consequence of):						
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	. If yes, outcome of pregnanc Live birth Pregnant at time of death Unknown	Fetal death 3  Other (Specify)	Ectopic pregnand	су	23d. Date of delive Month	Day Year	
res that the c signed by the be detached d by Phy	Part II. Other significant conditions contri	buting to death but not resulti	ng in the underlying cause	given in Part I.			o the cause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P		-			24a. Was an autopsy performe	prior to	utopsy findings availa completion of cause of res 2 No	
Vital Final Properties: director, o Be C	25. Was case referred to medical examiner?  1  Yes 2 No	l: 1 Inpatient 2 ER/	26.Plac	Other Nursing		esidence 6 🗸 Othe	er: Scene	
Sion of Attending Ph death. sctor: After ty the funeral cation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month Day Year)	E0 b		8d. Describe hov edestrian str	winjury occurred ruck by auto		
Division o spital or Attending hours after death.  neral Director: Aft, filled in by the fune.  Certification:	3 Suicide 6 Could not be determined (	8e. Place of Injury - At home, Specify) Local Street		2	ng, etc. 28f. Location (Street and Number or Rural Roi or Town, State) 27570 Three Notch Road, Mechanicsville			
To the Hospital within 24 hours To the Funeral completely filled	one) 2 ✓ Medical Examiner: On the	o the best of my knowledge, d e basis of examination and/or nanner stated.	investigation, in my opinio	n, death occurred at	the time, date an	d place, and due to t	the cause(s)	
Σ	29b. Signature and title of certifier			.M.E.		29d. Date signed <i>(M</i> December 1, 20	•	
5+1		stant Medical Examine		t, Baltimore, MD	21201			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27^{Day} NOV 2009 ELSIE PAULINE ZALINSKI 8:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** POOLESVILLE MONTGOMERY 19220 HEMPSTONE AVE. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Director DEC 9 1942 MD 214-42-3770 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, ITE Medical Examinations in Afficial at 10c. City, Town or Location 10a, State 10d. Inside City Limits Funeral Director 1 Yes 2 No MD MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20837 19220 HEMPSTONE USA AVE. 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Ş Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) COUNTY SCHOOLS BUS DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELSIE PEARL MUMFORD PARIS WESLEY LAMBERT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEANA BURDETTE / DAUGHTER 805 4th AVE., BRUNSWICK, MD 21716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 11/30/09 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HILTON FUNERÁL P.O. BOX 86, B L HOME BARNESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LUNG CANLER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 igned by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1∐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I 29c. License number 29b. Signature and ti 29d. Date signed (Month, Day, Year) NI November 30, 2009 33 6 35

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Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month,

OLNEY

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

18 111

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23aPtI, per me,g898,12/18/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician William Melvin Adey 40 pm Ovember 22 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Samare Rosedale Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, March 23, Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1**%** M 2 □ F Months Davs Hours Min. 60 216 52 1939 Director 1949 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
amplorant: If item 27 is marked other than "natural", or items 23a or 28a-f show
amplo injury or other traumatic event, the Medical Exprinter must be notified at
once. Director Maryland Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3823 Bayville Rd. 21220 USA Funeral 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 X Yes 2 □ No 1 ☐ Never Married 2 X Married M//am Huとり Baltimore, Maryland 21215-0036 1 □Yes 2X No δ If Yes, Give Vietnam Year or Dates: Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Metals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Riley William Adev Shirley May Tracey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Adey (Wife) 3823 Bayville Rd. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 11/23/2009 Baltimore, Maryland permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, ohn W. Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, clock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due that as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and ned for use as the burlal-transi Due to (or as a consequence of) P.O. Box 68760 Myocardial Infarction Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown in by the funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 ☐Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner?

1 ▼ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? of or Attending F after death. Olrector: After 5 Pending investigation Division 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Sandhya 30. Name and address of person who controlleted cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

18 2000

n 9000 From
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2009 12:30 AM Vera Arvin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAMARITAN HOSPITAL GOOD BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 □**X**F Hours 1/2-6-1945 Yrs 213-44-9484 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 E. 22nd Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Black 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MARCH FUNERAL HOME other than Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist 12th grade 17. Father's Name (First, Middle, Last) Raymond Ayers 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H, Important: If Item 27 is marked ofl any injury or other traumatic even once. Virginia Bolling 19a. Informant's Name/Relationship Gype, Print Granddaughter Tiara Williams-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 Balto, MD 21218 Bonaparte Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 12-22-09 Randallstown, MD 21. Signature of Funeral Service Lipense 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNGUMONIA

Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner ACCI DENT REBROVASCULAR Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Pregnant at time of death the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART CONGESTIVE FAILURE 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b CORONARY Were autopsy findings available prior to completion of cause of death? ARTERY DISEASE 24a. Was an 1 Yes 2 No Yes 2 V Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 욘 within 24 hours after deaun.

To the Funeral Director. After this commieted filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniurv 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier RES 000 12/17/2009 RAM BELBASE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN

DHMH 17 Rev 7/2009

State Registrar 560L

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	Certificate of Death	Reg. No.	109 4040
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middle,Last)  6 CALEVA CLIZABETT+	BOYD	2. Date of Death Month Day Year December 4, 2009	3. Time of Death 1228 hrs
1		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of D Frederick	Death 4c. County of I Frederick	Death
Funeral Director		219-66-4375 1 M 2 F 5	yrs. last birthday)  If Under 1 Year If Under 2  Months Days Hours	4Hrs. 8. Date of Birth(MM/DD/YYYY) Min. April 7, 1958	9. Birthplace (State or oreign Country)
land f show any once.	or	MD FREDERICK F	City, Town or Location		10d. Inside City Limits  1 Yes 2 No
the Mary	Director	10e. Street and Number 1600 JEINNINGS (OUR"	7 10f. Zip Code 2/702	10g. Citizen of What	107 E
after death with the Maryland "a", or items 23a or 28a-f sh iner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 N 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.) White, e	American Indian, Black, etc.
2 hours "natur	٤	3 Widowed 4 Divorced If Yss, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)	d) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	d of work done 16b. Kind of Busin	ness/Industry
215-0036 be filed within 72 ntal Hygiene. rked other than "	Completed	12 TH 17. Father's Name (First, Middle, Last)		Name (First, Middle, Maiden Surname)	AURANT
Z = 용 를 함	To Be (	MRURI(EE.BOYA, SR 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numbe	r or Rural Route Number, City or Town,	State, Zip Code)
_ 5 E E E			11807 (LEARVIEW  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - C	ity or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	crematory or other place)  FAIR VIEW Com. Do.  22. Name and Address of Facility  1/0 WCST SO V	11,2009 FRED	ERICR MD.
Balt Permit. Depart Import		20a. Fait i. Lings the disease, or complications that caused the de	eath. Do not enter the mode of dying, such as card	17+ ST FREDERIK liac or respiratory arrest, shock, or heart	Approximate Interval
/Medical xaminer	ì	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  The failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of the failure of th	atherosclerotic cardi	ovascular disease	Between Onset and Death
1	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)			
si ed C	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence)	ice of):		
760, cate be execut physician and he burial - tra	Medical	X UNPENDED AMENDED 23a . 27 . D	erME, g898 12/21/09 TT		
	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	pregnancy  2 Fetal death 3 Ectopic pr	230. Date of de	elivery Day Year
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n of Vita ding Physicia 1. After this cel	의	1 ✓ Yes 2 No Hospital 1 ✓ Inpatient 2	P ER/Outpatient 3 DOA Other N N 28b. Time of Injury 28c. Injury at Work?	lursing Home 5 Residence 6 28d. Describe how injury occurred	Other:
Sion C Attending death. ector; Afi by the fun	Certification:	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No	0	
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		4 Homicide determined (Specify)	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	
To the II. To the Fr	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.		red at the time, date and place, and due	e to the cause(s)
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed December 6	(Month, Day, Year)
0	Ī	30. Name and address of berson who completed cause of death (I Jack Titus MD. Deputy Chief Medical Exami	·	D 21201	
Sta	ite	31. Date filed (Month, Day, Year)  JEC 1 0 2000	gnature		

09-09643

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lawrence Boone State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Month Day December 11, 2009 wonl **Medical Examiner** 1558 hrs awlence 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3009 Thorndale Avenue Baltimore 5 Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 214-40-9742 Days Hours oreign Director 1 UM 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits NA 1 Yes 2 No Pages I and 2 should be filted within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Director 10e. Street and Numbe 10g. Citizen of What Country? horndalo Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1 Yes 3 Widowed Divorced Yes, Give Year Yes 2 No specify: 4 Specify \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 rounde 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) event, cone margaret Na 19b. Mailing Address (Street and Number or Rural Toute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edgewood NX daughte "Balto, nd, 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State tant: If it crematory or other place) 1 Burial 2 Cremation 3 Removal from State -18-09 MI Zun usdowne Donation 5 Other Specify: mut, 22. Name and Address of Facility 0 · rt Approximate Interval erune disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Imme lak Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate causs. Enter Underlying Causs (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last put Physician/Medical UNPENDED AMENDED sician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, attending physicor use as the bu 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has Yes 2 🗸 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) 8 examiner? Other A Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No I Director: Pending 2 Accident Investigation within 24 hours after To the Funeral Direc 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 12, 2009 **OCME** 30. Name and address of person who completed cause of death (Item 23a) 5 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December George Bucheimer, Jr. 2009 5:38 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 20 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1947 1 ₹M 2 □ F Days Hours Min. 62 Director 219-46-7785 Washington DC Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director MD Montgomery Kensington 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 University Blvd. 20895 United States ral", or items ! 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? þ Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 If Yes Give п Yes, Give Year or Dates.VietnamEra 1 ☐ Yes 2 X No Specify l Hygiene. other than "natural", Completed 3 Widowed 4 Divorced Specify: White th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Special Education Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည George Ε. Bucheimer, Sr. Patricia Mary Atwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Bucheimer / Brother 116 James St., Gaithersburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Chesapeake Crematory 4 Donation 5 Other (Specify) 12/18/2009 Beltsville, MD Signati of Funeral 8 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident M after death Director: / Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death Reg. No. 1 Defedent's Name (First Middle | 201 2 Date of Death **Physician** WRKE 200 10 /Medical 4a. Facility Name (If not-institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4104 Falls Road Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2√2 F 220-20-6358 81 Director 29, 1928 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event. The Modeal Examiner must be notified at XX Yes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4104 Falls Road 21211 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if Ifem 27 is marked other the any injury or other trainer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) File Assistant 7 Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Charles Fisher Bertha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Haney Daughter 4104 Falls Road, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 12/14/2009 Fullerton, Maryland 21. Signa ur of Funeral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hillioscherotic Physician Land disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine Due to (or as a consequence of): burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 □Wo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1710 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

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	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, It e Medical Experiment be profiled at	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 1	3. Was Decedent of H	dispanic Origin?	(Specity Yes or No-		ce - Americ	can Indian,
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Bal	Baltimore permit. Pages 1 Department of F Important: If ite any Injury or of		21. Signature of Funeral Service Li	vensee		22. Name and Addre	ss of Facility Br low Spr	adley-As	shton d, 212	FUne 222	eral Home
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State Registrar 31. Date filed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #5 State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar 40413 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 December Erna Amelia Seland Blaner 7:10 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Bethesda Montgomery Hospital 5. Social Security Number 2 8. Date of Birth (Month, Day, March 12 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days . 1921 1 □ M 2 🏻 F Months Hours Min 175-20-<del>3602</del> Germany 88 Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery North Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11710 Old Georgetown Road, #1402 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify. 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Payroll Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhem Fredrich Seland Augusta Niedballa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Blaner/Son 100 Haven Avenue, Apt 3H, New York, NY 10032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State December 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2009 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Signature of Funeral Service Licens M01548

Physician/ Medical **Examiner** 

Physician/

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**Examiner** 

**Funeral** 

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Baltimore, Maryland 21215-0036

ng physician and as the burial-transit Division of Vital Records, P.O. Box 68760 attending p nse þ has

or Attending Physician:

certificate To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu

20 State

	shock, or heart failure. List only or	ne cause on each line.	mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure  Due to (or as a consequence of):				000 and Death
er	Sequentially list conditions,	b. Sepsis  Due to (or as a consequence of):				72hrs-7days
l Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or iniplry that initiated events resulting in death) Last	c. Perineal Fistula  Due to (or as a consequence of):	_			7-14 days
edica		d				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown		opic pregnancy er (specify)		23d. Date of de Month	alivery Day Year
ed by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underl	ying cause given in Part I.			o the cause of death?  Probably 4 🛚 Unknow
Complet				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 \square No
Be (	25. Was case referred to medical examiner?		26. Place of Death (Check	only one)		
To E	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hor	me 5 Residence 6	Other (Spec	cify)
ficate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		work?	28d. Describe how injury	occurred	
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and City or Town, State)	d Number or Ru	ıral Route Number,
Medica	(Check 2 Medical Examin	sician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation to Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and place	and due to the	cause(s) and manner sta
	29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Mont	h. Dav. Year)

DOOKOILT

8600 Old Georgetown Road, Bethesda, Maryland 20814

December 11,

2009

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Eric Joon-Shik Park,

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 40414 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 12 2009 December 3:33 P M William C. Byrne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Greater Baltimore Medical Center 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birth Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F 217-22-0264 80 **Director** Aug 30, Maryland Usual Residence of Decedent 10a. State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinating the molified at Director 1 ☐Yes 2 ☑ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Kenilworth Park Drive #2B 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: 151- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: white 3 Widowed 4 Divorced **'**51-56 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sign painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susie Estell Loats ို Arthur Mark Byrne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Byrne/spouse 105 Kenilworth Park Drive #2B Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 N Donation 5 Other (S) ecity) 21. Signature or Ronald S. Wale, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) //myotrophic months /Medical Due to (or as a cons quence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (oras a consequents of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed sician and burial-trans Due to (or as a consequence of): the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 1 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: The within 2

funeral director, After ours after death.

24 hours a completely

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Э.	Signature and title of certifier	Robert	Mr

29c. License number DOO 43483 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles St. Baltimer Up 21204 65 35 Brian filed (Month, Day, DEC 18 32. Registrar's Signature

State Registrar

Medical

29

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 N Q 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Howard Thomas Cuff 06 6:12 pM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Hours 93-07-704 **Director** Usual Residence ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director PREDERICK FREDERICK MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 Mc MURRA U5 A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BCACK "natural", 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Y ARD HAVAL SHOP College (1-4 or 5+) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) the NAVAL ARCHITECT YVS traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PRICE CUFF CARRIC EDWARDS Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mc MURRY St FREDERICK MD 21701 THOMAS M. CUPF 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Phil. MULY SEPULUHRE CEM. DEC. 14 2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility GARYL. ROLLING PUN ISOME yeny L. FREDERICK MD 21701 Kolley 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shock Hypotensive Hours disease or condition resulting in death) Medical Due to for as a consequence of Examiner Hours Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Yes detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗆 No certificate 1 Yes 25. Was case referred to medica **Division of Vital** or Attending Physician: rector. Be 26. Place of Death (Check only one) examiner? Hospital 2 **N** No Other: 1 Yes 은 2 ER/Outpatient 3 DOA funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, 5 Pending s after death.

Il Director: Af М 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours at To the Funeral D completed filled in the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D62180 December 7,2009 son who completed cause of death (Item 23a) (Type, Print) 400 West 7+4 St

Registrar
DHMH 17 Rev 7/2009

State

09-09671 Gregory Chase

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 40416

jory Chase			or State of Maryland / Department of Health		Reg. No		
Physicia		1. [	istrar lecedent's Name (First, Middle,Last)		2. Date of Death Month Day December 12,	Year	3. Time of Death 1640 hrs
dical Exami	ner	42	Gregory Eugene Chase Facility Name (if not institution, give street and number)  4b. City, Tow	m, or Location of Dea		c. County of Deat	1
		10.	5028 Palmer Avenue Baltimor				/A
Funeral Director		1	Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1   Months   19-62-1249   1x   M 2   F   54   Yrs.		Aug. 13	, 1955 C	thplace (State or Foreign Ountry) Maryland
			Jal Residence of Decedent  State 10h County 10c. City, Town or Location				10d. Inside City Limits
ow any			a. State 10b. County 10c. City, Town or Location ryland N/A Baltimore				1 X Yes 2 No
ryland ia-f sh	cto	10	e. Street and Number	ode	10g. C	itizen of What Co	ıntry?
the Ma a or 28	Director	2	137 Hollins Street 212			USA	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland realth and Mental Hygiene, term 27 is marked other than "matural", or items 23a or 28a-f show trannaite event, the Medical Examiner must be notified at ouce.	Funeral	11 1	Never Married 2 Married Armed Forces?	of Hispanic Origin? ( Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	White, etc.	rican Indian, Black,
ifter de il", or ner mu	S		Widowed 4 Divorced If Yes, Give Year 1 Yes 2 7	_	Tack Tack	Specify: b. Kind of Business	Black
hours a natura Examin	eted by		5. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Orduring most of working	ccupation (Give kind ng life. DO NOT use	noticed)		Memorial
36 iin 72   ii. 12   iii. 14	1 to	i   20 t	Elementary/Secondary (0-12) College (1-4 or 5+)  A grade  Maintenar	nce	В	aptist	
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21215-0036 build be filed within 7 I Mental Hygiene. marked other than in event, the Medica	8		Herbert Chase	Evel	yn Brown or Rural Route Number	, City or Town, Sta	ate, Zip Code)
should and Maric on maric of	15	- 1	a. Informatio Hamor teleprotein (1)		eet Balti	more,Ma	ryland
e, M 1 and 2 Health item 2		2	Da. Method of Disposition 20b. Place of Disposition (Name	e of cemetery,	Date 20	c. Location - City	or Town, State
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner:		1	X Burial 2 Cremation 3 Removal from State  Mt. Zion ceme				e,Maryland
Saltin rmit. epartm nports		2	Signature of Funeral Service Licensee     22. Name and A	Address of Facility C	hatman-Ha	rris Fu	neralHome
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To th withir To th	comp	Medical	and manner stated.	9c. License number			(Month, Day, Year)
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			Zublandi / ui,	eet, Baltimore, N			
		ate trar	31. Date filed (Month, Day, Year)  DEC. 18 2009				

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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	(	2). Signature of F	uneral service L	Sha	)()			assa						timore,		
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Box 68760 e death certificate be the attending physic ed for use as the bu	cian	past 12 mont		1 4	Live birth Pregnant	at time of de	-41.	etal death ther (Spe	cifv)	Ectopii	c pregna	ilicy		North		.,
Box death he atte d for u	ysic	1 Yes 2	No 9 🗸 Unki	nown 9	Unknown											
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate by After this certificate has been signed by the attending physic funeral director, page 2 should be deached for use as the bur	by Phy		nificant conditi	ons con	tributing to de	ath but not r	esulting in the	underlying	cause g	jiven in Pa	art 1.				_	he cause of death?
Division of Vital Records, P.O. na or Attending Physician: The law requires that the safter death.  The inverse After this certificate has been signed by all pirector. After this certificate control to dead the funeral director, page 2 should be deadd	ed											24a. W				opsy findings available
ord aw req as bee 2 shou	Completed											au	topsy		ior to co eath?	ompletion of cause of
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of Vi Phys eral di	1.	27 Manner of De	2 No		28a. Date of I	njury	28b. Time of			ıry at Wor		28d. Descri		w injury occurre		
on C anding ath. Fr: Aff	Certification:	1 Natural	5 Pend		Dec 13, 20	v Year)	0810 hrs		1	Yes 2 🗸	No	Passenge	er au	ito auto colli	ISION	
/iSic r Atte her des hirecto	fica	2 Accident 3 Suicide		tigation i not be	28e. Place of	Injury - At h	nome, farm, str	eet, factor	y, office b	ouilding, e	etc.	28f. Location	on (Str	eet and Numbe te)	r or Rui	ral Route Number, City
Div pital o burs af eral D	Fire	4 Homicid	e deter	mined			d / Highwa							te) Road, White H		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici or other fulled in by the funeral director, page 2 should be deached for use as the built.	1 2		Certifying Pt  Medical Exa	ysician:	To the best of	my knowled	dge, death occ	urred at th	e time, d v opinio	ate and p	lace, and ccurred	d due to the d at the time, d	ause( late an	s) and manner and place, and du	as state ue to the	ed. e cause(s)
To th Within To th	Medical	29b. Signature a		an	d manner state	ed.				se numbe				29d. Date signe		
	2	C Signature a	AA ]							M.E.				December	14, 20	009
19		30. Name and a	ddress of person		pleted cause of	of death (Ite	m 23a)				-					
\			Vincenti, M		sistant Me			11 Penn	Street	t, Baltin	nore, N	/ID 21201				
	Stat		onth, Day, Year)	1	32. Regis	strar's Signa	ture									
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year John Robert Chenoweth Jr. 1412 PM 12 5 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Rosedale Square HOSPITal Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan.15,1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 213 30 1999 **Director** 75 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryiand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Directo Maryland Baltimore Essex 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Sue Grove Rd. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐Yes 2 X No Specify Specify: White ۾ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician 11 Sears Roebuck & Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental Marie Dietz John Robert Chenoweth ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tra Mildred Chenoweth (Wife) 912 Sue Grove Rd. Baltimore, Maryland 21221 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 12/17/2009 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. lotion 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bus to for as a consequence of Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> icate has been si , page 2 should ₺ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 XYes 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1¶X Yes 2 □ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Hospital or Attendi 24 hours after death, Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of caufier AL8 717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPhen Selin 9 6 ( 9000 Sanara Diz Md21237 FRANKLIN 31. Date filed (Month, Day, Year)
DEC 18 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#17 Per FH C898 12/18/09 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. P44 2009 11:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Baltimore** Cockeysville 10609 Virginia Ave. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months Days Hours (Month, Day, Year) CONN^C Director 13-28-880 80 Usual Residence of Decedent 28a-f shov 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tyes 2 XNo altimac 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21030 Virginia 10609 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Highway and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) Superintendant Administration Be 17. Father's Name (First, Middle, Last)
Amos, Wesley, Cole 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Nina Clifta Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State Zip Code)
10609 Virginia Ave., Cockeysville, MD 21030 Wayne Clifton Cole/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12/17709 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cem., Phoenix, MD 4 ☐ Donation 5 ☐ Other (Specify) Poplar Grove United Meth. Ch. ^{22. Name and Address of Facility} Lemmon Funeral Home of Dulaney Valley, <u>10 W. Padonia Rd., Timonium, MD 21093</u> 23a. Part 1. Enter the disea shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Athenosclenosis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine sician and burial-transit executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate be Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 1 No
9 Unknown Month Day ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ woon Polyps Gastritis Duodenal Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 S 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State, within 24 hours a

To the Funeral D

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cartifying Nurse Practioner: To the best of my knowledge, death concurred at the time, date and out to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ene 1005 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4b. City, Town, 4c. County of Death Memorian Battimore Social Security Number . Age (In yrs. last birthday) 39 Yrs. If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country) Marylar 1 🗆 M 2 🗓 Months Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ivaria Ave. #2B Funeral UST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FACKAGE Hard 27 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jack W Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurg Route Number, City or Town, State, Zip Code) 2-13-0 Carter -515Ter 900 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Man 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) any a Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated second Examine Due to (or as a consequence of): death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death
Unknown signed by the a d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, should ! Completed 1 Yes 2 No 3 Probably 4 Unknown £4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law cate has page 2 s autopsy certificate 2 🗌 No Yes 1 ... Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 9 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 2 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tirne, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2438946 200° 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Universi 6015 over 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ye ar Deborah Clark 3 8:40 Ann 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL KOSEDALE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 KF 215-90-8519 47 Director Sept. 18,1962 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 8321 Bear Creek Drive Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify. à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Child Development 12 Years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Larry Cobb Catherine Louise Harris ည 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward J. Clark, IV 8321 Bear Creek Drive Dundalk, Maryland 21222 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Service Corp. 12/17/2009 Towson, Maryland 4 Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, re of Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER disease or condition resulting in death) UNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital: Other: ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

law requires that the death certificate be executed attending physician of for use as the burialcertificate

with the Maryland

72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than "

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signed by the a page

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al Director: A
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State

Registrar

29b. Signature and title of certifier BINH NGULT MP

IEN

6 Could not be determined

NG

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only

30. Name and address of person

31. Date filed (Month, Day Year)

DR. BINH

29c. License number D65094

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) 9000 FRANKLIN S'QUARE DR. BALTIMORE, MD 21237

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a,26,30 per dr., 2898,12/17/09dhb
Certificate of Death

Red, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Connor arolyn NOV 2009 30 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Secours Bon Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/20/1966 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 💁 F Yrs 43 213-06-3445 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modical Examiner must be notified at 1 XYes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 425 Easlynn 21229 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐Yes 2 XNo Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. 2 Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Park West permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the "Motto once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health information tech Health System 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosevelt ဂ္ Connor Shirley Rivers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Candrier Holloman(Daughter)5020 Denview Wayland, Baltimore,MD 21206 20b. Place of Disposition (Name of Jemelery, crematory or other pl Joseph Brown And Cremation Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/07/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 21. Signature of Funeral Service Licensee Mans MD21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician omin disease or condition resulting in death) /Medical Due to (or as a consequence of) Renal Failure Examiner ngertite Sequentially list conditions Examiner or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Morbid Obesity To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 □ No 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 3 Aesidence 6 Other (Specify) 1⊈Yes 2□No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 2005 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Attending 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO063565 Physician SBean- Thompson

State Registrar M.D., Bon Secours Hospital, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Sherron Benn-Thompson,

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		•	for State Registrar	Otato of Wary	Cei	tificate of L		Re	g. No.	3 40423		
	Physicia	ın/	Month DayYear						3. Time of Death			
	Medic Examin	al	Jacqueline A. Covert  4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		Decembe	4c. County of De			
فجمس	Examin	er	Gilchrist Hospice			Towso			Balti			
	Funeral Director		064-28-3658	M 2 X F 7. Age (In yi	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y May 29,	(ear) 9. B	sirthplace (State or Foreign Country) ew York		
	and show at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation	<del>-</del>	<del></del>		10d. Inside City Limits		
	Maryla 28a-f		MD Baltimon	re	Coc	keysville	2			1 🗆 Yes 2🏋 No		
Baitimore, Maryland 21215-0036	n with the is 23a or 2		10e. Street and Number 13801 York Road			10f. Zip Code	21030		og. Citizen of What C	Country?		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 Widowed 4X Divorced	Was Decedent Ever in Armed Forces?     □ Yes 2 \( \frac{N}{2} \) No If Yes, Give Year or Dates.	- 1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W			
	ithin 72 ho ene. r than "nat the Medica		15. Decedent's Edu- (Specify only highest grade Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occup kind of work done ( O NOT use retired) CCOUN <b>t</b> ant	during most of work	ing 1	6b. Kind of Busines	,		
	should be filed won and Mental Hygin and Mental Hygin is marked other raumatic event, it		17. Father's Name (First, Middle, Last) Denton Howell Co			_	18. Mother's Nam	e (First, Middle, Ma en Emma R	aiden Surname)			
, Mary	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Турк Ann Keeler/daugh	e, Print) ter	19b. Mailir 304	ng Address (Street Normandy	and Number or Rura Drive Si	A Route Number, C 1ver Spr	City or Town, State, 2	Zip Code) 20901		
imore	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)		b. Place of Dispo cemetery, crer	osition (Name of natory or other plac	ce)	Date 2	9c. Location - City	or Town, State		
Balt	permit. Depart Import any inj		21. Sign to of Funeral Service Licensee Ronald S. W	as reget	or Si	2. Name and Addre tate Anat altimore.	ss of Facility omy Board MD 2120	l 655 W.	Baltimore	Street		
7	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Vist only one cause on each line.  Immediate on set (Final disease or complication)									
	Medical Examiner		resulting in death)  Due to (or as a consequence of):									
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury that initiated events	sequence of):	quence of):							
ည	tificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a cons	sequence of):							
0	certific nding use as	Physician/Me	in the past 12 months?	ic. If yes, outcome of pre  1  Live Birth 2  4  Pregnant at time  9  Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of o	delivery Day Year		
	requires that the death been signed by the atte should be detached for	by Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the conditions contribute to the conditions.							to the cause of death?		
ords,	requires been sig should b	Completed						1 🗌 Yes	24b. Were	Probably 4 Unknown autopsy findings available		
Rec	The law ate has page 2		SE Was and Associated									
/ital	/sician s certif directo	To Be								ecital Porpin		
on of	To the Hospital or Attending Physician: Within 24 hours after death or the Funeral Director After this certific completed filled in by the funeral director,	Medical Certificate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28b. Time or injury	Bb. Time of 28c. Injury at 28d. Describ			ibe how injury occurred				
Division of Vital Records,			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fi building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	he Hospi in 24 hou he Funer pleted fil		(Check 2 Medical Examine	ian: To the best of my kr r: On the basis of examin Practioner: To the best of	ation and/or inves	tigation, in my opini	on, death occurred a	t the time, date and	place, and due to th	e cause(s) and manner stated.		
	To t With To t		29b. Signature and title of certifier  FGW (SO FO) - W	wilmo,	1	29c. Licens	e number	79	d. Date signed (Mor	nth, Day, Year)		
			30. Name and address of person who con	mpleted cause of death (	Item 23a) (Type, I	Print) N.C	harles	treet	, Towso	7W50n, MD 21204		
State 31. Date filed (Marylin, Day, Year) 2009 2. Registrar's Signature												

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^{Year} Month **Physician** December 4:45 AMM Wilma Connor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year, Jan 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 1 □ M 2 1 F Months 1942 Director 566-64-4092 67 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be multified at 1 ☐ Yes 2☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7409 Castlemoor Road 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: white þ Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) front desk clerk motels 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Percy Earl Connor မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traun 2592 Hayden Drive Lake Worth, FL Robert Bailey/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in Signature of Funeral Solvice Licensee Ronal d S Wards 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Birector Raltimore, MD 21201 23a. Part 1. Enter the displace, in complicit in sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate See (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the attending physician and the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 3 Probably 4 ☐ Unknown 2 □ No 1 🗌 Yes Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manger of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Division 1 ☐Yes 2 ☐No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Hospital Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Johns Hopkins Bayrian medical Center 4940 Eastern Ave e Kachel Vine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Nemoria 20 m ort If Under 24 Hrs. Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Month, Pay, Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 33rd 1609 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) HUD Be 17. Father's Name (First, Middle, Last) ပ္ one Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 9 20a. Method of Disposition 20b. Place of Disposition (Name of 12 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 23a. Part 1 Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 8

Registrar

State

ochtaven

cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year JENNIE ENGLE 21.3 8 PM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Year If Under 24 Hrs. Montcomery
9. Birthplace (State of Foreign Takoma 7. Age (In yrs. last birthday) 8. Date of Birth Date of Bill. (Month, Day, Year) **Funeral** 1 M 2 XF Months Hours Min. Director 225-36-2972 Usual Residence of Decedent 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 X Yes 2 No HUGHSVI 10e. Street and Number 10g. Citizen of What Country? Funeral 31st Ave 5902 20783 and 2 should be filed within 72 hours after death ' Health and Mental Hygiene, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 No Specify: 3. Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1920 Accountant is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ 27 is marked r traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levrel, MD South Bruce St 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) altimore, 21. Signature of Funeral Service License 23a. art 1 End r the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiral ry arrest shoot in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Septic Shock failure multisystem organ Medical Due to (or as a consequence of): Examiner thrombosis Arterial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Heparin Induced thrombory topenia Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Cardomyonathy Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No Chronic 1 ☐ Yes 2 ☐ No Yes ospital or Attending Physician: ' hours after death. uneral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD MD 59318 Dec. 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAM Afkham - Ebrahimi 2101 Medical Park Dr.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, DEC 18

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kevin Eugene Elza, Sr. Month 2009 December 7:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2113 Larkhall Road Dunda1k Baltimore Co. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. (Month Day, Director 217-54-0734 58 April Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 XXVo Maryland Baltimore Dunda1k 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 2113 Larkhall Road 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 A Married Yes 2 TNO Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the d 2 should be filed with alth and Mental Hygien 27 is marked other the 11 Years Operatoring Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Orville F. Elza Mabel L. Skidmore other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important If item 27 is any injury or any 2113 Larkhall Road Dundalk, Maryland Deborah L. Elza (Wife) 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 12/16/2009 ▶☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, NETASTATIC disease or condition MORITHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury One to forms is excessionaries of Exami Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ourial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No the a g Unknown q | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signature beautiful to the should be shou 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2X No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🐪 Residence 6 ☐ Other (Specify, 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. work? 1 ☐ Yes 2 ☐ No 5 Pending injury safter death.

Director: Aft
d in by the fur Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i Medical

Registrar

29a, Certifier (Check

only one)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 22:20 December Alfred Joseph Farina, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.18,1933 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours NY 76 134-26-3849 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Anne Arundel Laurel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 20724 333 Old Line Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4or 5+) Elementary/Secondary (0-12) Human Factor Psychologist Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jakubek Alfred Joseph Farina, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If item 27 is r 333 Old Line Ave., Laurel, MD 20724 Lillian E. Farina/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 N Burial 2 □ Cremation 3 ☐ Removal from State 17, Dec 4 □ Donation 5 □ Other (Specify) 2009 Crownsville, MD Maryland Veterans Cem. 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Ave., Laurel, MD 20707 . Ken Stelle M01053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diabetes Medical Due to (or as a consequence of) **Examiner** Hyperstension Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed CAD burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 🗌 Yes 2 No 3 Probably **X**XUnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√√No 24a. Was an autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ATNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation **⊅**XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ို December 13, 2009 D66945 Xu D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Carter, MD, 7300 Van Dusen Rd., Laurel, MD 20707

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For Amend Items 23	tate of Maryland / Department art 1,23 per me , g898, 127 Certificate	of Health and Ment of Death	al Hygiene Reg. No 2009	40429
Physicia /Medica	( 11 A ) ( ) — C	FEDONCZAK	M	ate of Death John Day Year	3. Time of Death
Examine	4a. Facility Name (If not institution, give stre	et and number) 4b. City, To	own, or Location of Death	4c. County of Death	
Funeral Director	Social Security Number     6. Sex	7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. 8. Days Hours Min.	ate of Birth 9. Birth footh, Day Year)	place (State or Foreign intry)
yland	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Location		1777	10d. Inside City Limits
the Mar 28a-f sl	10e. Street and Number	5, 1635 GKAY	HAVEN C	10g. Citizen of What Cou	1 □ Yes 2 🗗 No ntrv?
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Taryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, II.M.	17. Father's Name (First, Middle, Last)		18. Mother's Name (First	t, Middle, Maiden Surname)	
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Baltimore, Dermit. Pages 1 an Department of Heal Important: If Item 2 DICE.	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name cemetery, crematory or othe	er place)		7. 2/20 2 own, State
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	snock, or neart failure. List only one c	ons that caused the death. Do not enter the mode cause on each line.	of dying, such as cardiac or resp	piratory arrest,	Approximate interval Between Onset and Death
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ANON C BRATN T	NJURY		
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. State	131. Date filed (Month Day, Year)	32 Registrar's Signature	ASTERN AVEN	UE BALTIMOR	E MD 2 224
Registra		Chama B. garles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10c&d Per FH G898 12/23/09 JH

State of Maryland / Department of Health and Mental Hygiene

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	/Medic Examin						4b. City, Town, or Location of Death 4c. County of Death					
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21215-0036			1 □ Never Married 2 □ Married 1.5 3 ☒ Widowed 4 □ Divorced Ye  15. Decedent's Education	Yes 2 □ No es, Give ar or Dates: ARMY		I □Yes 2 No			Specify:	White		
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Maryland	ld be f ental I ked of		Samuel Feith				Sarah	Storch	waiten Surname)			
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nore	ages 1 int of F t; If Ite / or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	ii irom State		sition (Name of natory or other pla	i - •	Date	20c. Location - C		ie.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 Is marked any injury or other traumatic ev once.		4 Donation 5 Other (Specify) Final Journey Crematory 12/18/2009 Woodbine, MD  21. Signature of Euneral Service Licensee Donata Manshall 22. Name and Address of Facility Maryland Cremation Services									
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14	Physician /Medical Examiner		23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Cancer									
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	equires that en signed b	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Probably 4   Yes   Yes 2   No 3   Probably 4   Yes 3   Probably 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Y							e of death?		
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on of	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use		TE 163 ZEVINO	1 ☐ Inpatient 2 ☐ I Date of Injury (Month, Day, Year)	ury 28b. Time of 28c. Injury at Work?  M 1 Yes 2 No  28d. Description of 1 Yes 2 No  28d. Description of 1 Yes 2 No  28d. Location of 1 Yes 2 No  28f. Location of 1 Yes 2 No			Home 5 Residence 6 Dother (Specify)				
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	he Hospi in 24 hour he Funera pletely fill	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							use(s)		
	Vith To t	Σ	29b. Signature and title of certifier  MSRajapanse, MID	29c. License number D00574465			29d. Date signed ( <i>Month</i> , <i>Day, Year</i> )					
•			30. Name and address of person who complete	25 NA	23a) (Type, I	Print)		sterstow			*	
	Sta	te	31. Date filed (Month, Day, EC 18 20	32. Registra's Signat	ure	,	/ .		/			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f. per me 8898,12/14/09dhb Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:20рм Nov 2009 Harold Payne Freeman /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Overlea Health & Rehab Center Baltimore 8. Date of Birth (Month, Day, Oct15 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1944 Days 1**√** M 2□ F Months Hours Min. 65 104 34 0020 Director Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities must be notified at once. Director Plainefield 1 Yes 2 □ No Union N.T 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1 Brooklane 07060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ∏Yes 2 ☐ I If Yes, Give Year or Dates 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mortuary Services College (1-4or 5+) Elementary/Secondary (0-12) Funeral Director & Embalmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John P Freeman Margaret Nicholas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4Shepard House Ct Catonsville MD Dr.May Nicholas-Holmes 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 10 09 Ardent Crem Hanover Maryland 22. Name and Address of Facility Phillip A. Weatherford FS PA E Oliver Street Baltimore 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EXAMINER and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Did tobacco use contribute to the cause of death? \$ 2 ☐ No 3 ☐ Probably 4 ☐ nknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1X Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of D 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Subject fell 9:00 p.M 01/10/2007 1 □Yes 2 X No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3125 Tamora Drive Charlotte, North Carolina 4 Homicide Home

be exect Division of Vital Records, P.O. Box 68760, law requires that the death certificate

cate has been signated by page 2 should b To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

32. Registrar's Sig

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 person who completed cause of death (Item 23a) (Pole, Print)

Soll-Lock Laven Blvd, Baltimore MO 21239

1 A 32. Registrar's Sichatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13^y 2009 Lucy M. Ferri 6:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 T+oly **Funeral** Months Days Hours Min. Director 213-26-6364 80 Italy Usual Residence of Decedent 10a. State 10b. County death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland N/A 1 X Yes 2 No Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6229 Pilgram Road 21214 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 <u>Kev Punch Operator</u> Health Care Industry Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grace D'Amico Joseph Cozzubo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Celeste Smith - Daughter 4409 Darleigh Road Baltimore, Maryland 21236 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 X Other (Specify Entonoment Gardens of Faith Cemetery 12-17-2009 Baltimore, Maryland Funeral Service Vice 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a ISCHEMIC HEART DISEASE Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 9 Unknown Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed: 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဂ္ 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Xe

JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 Register's Signature

CRNP

within 2 To the

p.m.

2300 DULANEY VALLEY RD.

3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

back

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2000

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15 FREEDMAN 2009 2:59 $P^{M}$ R MORRIS December 4a. Facility Name (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) 03-04-1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Min. 1 X M 2 □ F Months Days Hours 86 ΜI 215-12-7061 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 ROUNDWOOD ROAD, #1407 USA 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURERS REPRESENTATIVE SPORTING GOODS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHANSON FREEDMAN LOUIS BESSIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 STONE PINE COURT, PIKESVILLE, MD 21208 LARRY B. BERMAN/COUSIN 20b. Place of Disposition (Name of Date 20a. Method of Disposition MIKRO^{ter}KODESH^{or}BETH^{ce)} 1 Burial 2 Cremation 3 Removal from State 12-17-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) CONG. 21. Sign turn of Funeral Service Licenses ne and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stro Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liquiy that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves No 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

any.

**Physician** 

/Medical

Examiner

**Funeral** 

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28a-f show

Director

Funeral

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than '

Baltimore, Maryland 21215-003

Physician/Medical

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law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician: The

þ Completed Be ဥ Certification: After death. of Funeral Director: A Funeral Director: A sletch filled in by the funeral Director.

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	x 687  th certific  ittending properties or use as the	sician/	past 12 months	s?	4	Pregnant at time of 5 Other (Specify)				pregnan	ncy		Month		Day		Year			
1   25   No   1   27   No   1   28   No	the dea	ě.			9			not resulting i	n the u	ınderivina ca	use a	iven in Pa	rt I.	23e. Did	tobacc	o use contr	ribute to	the ca	use of a	death?
State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	, P.O res that signed b	۵												1 🗌 Y	es 2	<b>✓</b> No 3	Pro	bably	4 🔲 t	Jnknown
State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	ords aw requi as been 2 should	plete												aut	opsy		prior to			
29b. Signature and title of certifier  O.C.M.E.  December 15, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  DECEMBER  32. Registrar's Signature	Rec The I ficate I	팅												1 V Yes			<b>✓</b> Y	es	2	No
29b. Signature and title of certifier  O.C.M.E.  December 15, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  DECEMBER  32. Registrar's Signature	rital sician: is certi	ωſ	examiner?			ital: 1 🗸 In	patient 2	2 ER/Outr	atient		- 17				Resi	dence 6	Othe	 эг:		
29b. Signature and title of certifier  O.C.M.E.  December 15, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  DECEMBER  32. Registrar's Signature	on of V nding Phy th :: After th e funeral	۲	27. Manner of Dea	th		28a. Date o	f Injury	28b. Tir		· ·		-	10				red			
29b. Signature and title of certifier  O.C.M.E.  December 15, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  DECEMBER  32. Registrar's Signature	Divisic al or Atter as after dea in Director	rtificat	3 Suicide	6 Cou	ld not be	100			n, stree	et, factory, o	ffice bi	uilding, et	- 1	or Town	, State)	1				mber, City
29b. Signature and title of certifier  O.C.M.E.  December 15, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  DECEMBER  32. Registrar's Signature	he Hospit in 24 hou he Funer	ပြ	29a. Certifier (Check only			To the best	of my kno	wledge, death					ce, and	due to the ca	use(s)	and manne	er as sta	ited.		
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  12. Fegistrar's Signature  Registrar  32. Fegistrar's Signature	To To To Con	₩e				d manner sta	ated	_		29c. L	icense	e number			29	d. Date sign	ned (M	onth, D	ay, Year	r)
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  OCME			and	12_						(	D.C.N	M.E.			D	ecembe	15, 2	2009		
Registrar DEC 18 2009 Beneva A. Sparker									enn S	Street, Ba	ltimo	ore, MD	21201							
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FETNAN do A Delpedo

31. Date filed (Month, Day, Year)

Delpedo

ar's Signature

29c. License number

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29d. Date signed (Month, Day, Year)

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09-09731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brendan Thomas Geary State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 14, 2009 1140 hrs **Medical Examiner** 4b. City, Tolvn, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 389 Deale Road Tracys Landing 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex **Funeral** Foreign Months Days Hours Director Country 1X M Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Externiner must be notified at once. Yes 2 X No Director Shinalon 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Yes 1 Yes 2 No specify: Widowed Divorced If Yes, Give Year Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ٩ 19a. Informant's Name/Relationship (Type, Print (Street and Number or Rural Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of ce crematory or other place) 2 Removal from State Other Specify 5 er e disease, of complication ly one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval 23a. Part / Enter **Physician** Between Onset and /Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy . Was decedent pregnant in the 3 Ectopic pregnancy Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 ✓ Yes uneral director, 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene After this ို 1 ✓ Yes 28a. Date of Injury FOUND: Day, Year) 28d, Describe how injury occurred 28c. Injury at Work? 27 Manner of Death 28b. Time of Injury Certification: Subject entered water and drowned FOUND: Natural 1 Yes 2 ✔ No the f Pending within 24 hours after death.

To the Funeral Director: Dec 14, 2009 1050 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 389 Deale Road, Deale, MD (Specify) marina Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. December 15, 2009 30. Name and address of person who completed cause of death (item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Head State of Maryland / Department of Head Certificate of Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department of Head State of Maryland / Department / Department of Head State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department /		lental Hyو ه	giene Reg. No.201	09	40437
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Dea     Month	ith Day	Year	3. Time of Death
	/Media	al	Rose Giangiordano		Decembe	r 17, 2	2009	6:15 A ^M
	Examir Funeral Director	er	301 Tiree Court  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 20	Harfor 7 Year)	d 9. Birthola	ace (State or Foreign Y) York
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10	d Inside City Limits
	// Aaryla	ō					100	d. Inside City Limits 1 □ Yes 2 \ No
	the N	Director	Maryland Harford Abingdon  10e. Street and Number 10f. Zip Code			10g. Citizen of W	hat Countr	
	h with					J.S.A.		<u></u>
	ems (	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispa	anic Origin? (Spe			- America	
9036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygleine. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It. M. dical Erri: In. I. ut its intillised at	þ	If Yes, Give 1 ☐ Yes 2 ☑ No 5	Specify:	nican, etc.)		white, etc.	
2	72 hc "natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during the DO NOT use retired)	on ing most of workir	ng	16b. Kind of Bus	siness/Indu	stry
12	within ene. <b>than</b>	duic	Elementary/Secondary (0-12)  College (1-4or 5+)  Homemaker			Own Hom	ie.	
ر م	filed Hygi other ent,	Be Co		3. Mother's Name	(First, Middle,			
<u> a</u>	Aental rked o	To B	3	Santa Br	uno		,	
lary	2 should be filed wand Mental Hygie n and Mental Hygie 'Is marked other traumatic event, In	_	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and				State, Zip (	Code)
€,	1 and 2 Health em 27 i		Mr. Albert Giangiordano (Spouse) 310 Tiree Court, Ab					
Baltimore, Maryland 21215-0036	Pages 1 nent of H nt: If ite nry or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of commetery, crematory or other place)  Evans Terms (Name of Commetery, crematory or other place)  Pel - Air	Dec. 18	ate No I	20c. Location - 0	,	
Balti	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		21. Signature of Funeral Service Licensee  Eval's Funeral Service Licensee  Eval's Funeral Service Licensee  3 Newport Driv	Haber & C	remation	Services	- Bel	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, s			_		Approximate
	Physician		snock, or neathallure. List only one cause on each line.		, , , , , , , , , , , , , , , , , , , ,		1	Approximate nterval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):				_	
	Examiner							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):					
5-	xecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
68760,	ficate be executed physician and s the burial-transit							
687	ificate be executed g physician and ss the burial-transit	edical	d					
Box	eath cert attendin for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐			23d. Date Mon	e of delivery oth D	y Day Year
ν. J.	w requires that the d been signed by the should be detached	by Pł		in Part I.	23e. Did to	bacco use contri	bute to the	cause of death?
ğ	equire sen siç ould b				1 <b>2</b> Y	es 2 □ No :	3 ☐ Probal	bly 4 ☐ Unknown
Yes Yes	The lar	Completed			24a. Was a autops	med? pr	rior to comp eath?	sy findings available pletion of cause of
Vital	iding Physician: th. After this certifica funeral director, p	Be (	25. Was case referred to medical examiner?	6. Place of Death	1 ☐ Yes (Check only or		□Yes 2	
-	ا مق خ	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	4 ☐ Nursing Hon	ne 5 Resid	ence 6 □Othe	r (Specify)	
ב	Jing F	io io	27. Manner of Death 1 Matural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?		28d. Describe h	ow injury occurre	d	1
UIVISION	vttenc death ctor: y the	licat	3 Suicide 6 Could not be One Place of Latinus At home form that I'll	2 No	19f Logation (C			Davida Alivarha
≧ .	after after Dire	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Town	treet and Numbe n, State)	r or Hurai F	Houte Number,
, \	To the Hospifal or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, and manner stated.  13 Certifying Physician: To the best of my knowledge, death occurred at the time, and manner stated.	date and place, a ion, death occurre	and due to the o	cause(s) and mar late and place, a	ner as sta	ted. he cause(s)
	omple	Mec	29b. Signature and title of certifier 29c. License nu	umber	2	29d. Date signed	(Month Di	av. Year)
	F > F 0		Mola DAS	0564	49	12/1	7/0	)9
	5		20. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-1-7		, - 1	11,1	(halisala
		(	le - Jamonson III W High	St. S	ute 3	102 01	Kto	1 MD 2192
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Regina E. Gilliam 0:45 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore n/a Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Dec. 07 (1948 MD MD 1 □ M 2 ⋤ F 212-44-5986 61 Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2819 Ε. Federal St. 21213 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced الم Trian "الم. *he Medical F Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) housewife home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic evenones. မ William Lomax, Sr. Margaret Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Gilliam (husband) 2819 E. Federal St. Balto, Md. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) Woodlawn Cem. Dec.21,2009 Balto.Co, nature of Funeral Service Licensee Name and Address of Facility alvin B. Scruggs Funeral Home Calvin B. E St Balto, Md Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lardiogenic day Medical Due to (or as a consequence of): Examiner Myoravdutis week Sequentially list conditions, if any leading to immediate Examine Due to for as a consequence of if any, leading to immedi cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death detached the ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ þe 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? Yes 2 N 2 🗌 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 🗌 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.
e Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 12/16/09 MD 2438946-BI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdallah: Union Memorial 201 E. University Parkway, Baltimore, MD 21218 Hospital

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First Middle, Last) 3. Time of Death 2. Date of Death Physician/ Grogan Month 5.30A M 1000 Medical 4a. Facility Name (if not institution, give stre Examiner 4b. City, Town, or Location of Death 4c. County of Deat #306 Mills Graffs Mill OWINGS d If Under 1 Year Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-22 1 🗆 M 2 🖼 Months Hours Month, Day, Year 29 Country) 63 Director lana Usual Residence of Decedent should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Kaltimore Marylan 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 Funeral Mill 9773 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give aci 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Grove Elementary/Seconday (0-12) College (1-4 or 5+) Psychiatric Be 17. Father's Name (Firşt, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) မ EMMEST Woods Eleanor tarker other traumatic if. Page 1 and 2 shou...
if. Page 1 and 2 shou...
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if. First in m. 27 is m. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 6968 Glerheights Ka, Be City or Town, State, Zip Gode) Jeanor Williams - daughter Marylan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla Mills Garrisen Man Forest 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Evi ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed 226 1 is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 N N မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗆 No Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🖵 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODLA KOODNICK MD), 4000 Old M.D. Kroopnic

State Registrar 31. Date filed (Month)

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b Per Phys G898 /12/18/09 The Health and Mental Hydiene

		-	For State Of IVIARY  State Registrar		artment of Health tificate of Death	and Mental Hy	/giene Reg. No∩ ∩ ∩ ∩	10110
	Dhuaisia	~/	1. Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·	2. Date of D Month	eath ZUUS	3. Time of Death
	Physicia Medic		Florence	Marie	Gustke	Decemi	per 13,2009	9:50 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of Dea	
and a	Funeral		Brightview Assisted Living  5. Social Security Number   6. Sex   7. Age (In )	yrs. last birthday)	Whitema	arsh r 24 Hrs. 8. Date of Bi	Baltimo	ore Co.
	Director		215-16-9185	Yrs.	Months Days Hours	Min. (Month, D Apri.	ay, Year) C	ountry) irginia
	Iryland a-f shov ied at		10a. State 10b. County 10c	c. City, Town or Loc	cation		-	10d. Inside City Limits 1 ☐ Yes 2 🐼 No
	he Ma or 28a notif	Dire	Maryland Baltimore 10e. Street and Number		Essex 10f. Zip Code		10g. Citizen of What C	
	23a st be	Funeral	8620 Kelso Drive Apt.	A114	21 221		United St	
	items items	Fu	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hispanic Of Yes, specify Cuban, Mexica	ngin? (Specify Yes or No	- 14. Race - Am	erican Indian,
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Merikeal Examiner must be notified at	ed by	1 Never Married 2 Married 1 Yes 2 No 1f Yes, Give Year or Dates.		Yes 2 No Specify		Black, Whi	White
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12	ithin 7 ene. • than he M	Som	Elementary/Seconday (0-12) College (1-4 or 5+)		ONOT use retired)	ū	Own Home	
d 2	filed within 72 al Hygiene. d other than '	Be	12 Years 17. Father's Name (First, Middle, Last)	, HOME		her's Name (First, Middle		
/lan	d be fill Aental Irked tic ev	입	Howard Jackson			izabeth Col		
lan	1 and 2 should be fill the and Mental and Mental item 27 is marked other traumatic ever		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Numb	per or Rural Route Numb	er, City or Town, State, Z	ip Code)
€,	and 2 lealth em 27 her to		Gary L. Gustke (Son)		rse Chestnut		, Maryland	21221
Jor	ige 1 and of h		Burial 2 Cremation 3 Removal from State		natory or other place)	Date	20c. Location ~ City o	
Baltimore,	permit. Page 1 a Department of H Important; If ite any injury or ot		4 ☐ Bonation 5 ☐ Other (Specify)  21. gnatur Funeral Berus Losee			12/17/2009		Maryland
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ı,	and the same of		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			s cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
7	Pnysician. Medical		disease or condition resulting in death)  a.  Due to (or as a con		trest			1 Death
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P	icate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last Due to (or as a con	isequence of):				
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89	certif anding use a	M/us	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of precision to post 12 months? 1 ☐ Live Birth 2 ☐	egnancy	Ectopic pregnancy		23d. Date of de	elivery
P.O. Box	requires that the death certific been signed by the attending should be detached for use as	Physician/N	in the past 12 months?  1  Yes 2 No 9  Unknown		Other (specify)		Month	Day Year
P.0	that the	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in Par	t I. 23e. Did	tobacco use contribute t	o the cause of death?
ds,	quires en sig ould bo	ted t				1 🗆	lYes 2 XNo 3 □ I	Probably 4 🗆 Unknown
COL	2 38 3	Completed					opsy prior to	utopsy fi <i>n</i> dings available completion of cause of
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ita	sician: The certificate rector, pag	m	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: I I Inpatient		Other	ath (Check only one)		
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ou	ending sath. rr. After ne funer	ficat	1 X Natural 5 ☐ Pending (Month, Day, Yea 2 ☐ Accident Investigation	ar) injury	work? M 1 ☐ Yes 2 ☐	_		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp		eet, factory, office	ce 28f. Location (Street and Number or Rural Route Nu City or Town, State)		ural Route Number,
	Hospita 24 hours Funeral eted filler	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my k	nation and/or invest	igation, in my opinion, death of	occurred at the time, date	and place, and due to the	cause(s) and manner stated.
b	To the within 2 To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier	oi my knowledge, d	leath occurred at the time, dated	te and piace, and due to t	he cause(s) and manner a 29d. Date signed (Mon	
			1 Milel		DUTUTE	-	12/16/6	9
			30 Name and address of person who completed cause of death			arford Road ore, Maryla		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's S	0	Darcing	ore, naryra	114	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10 Gavis 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE Baltimore Ros edal e Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🖫 F Yrs. 84 Director 256-34-1343 Georgia 2,1925 Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f shore Director Dunda1k 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7852 Harold Road Funeral 21222 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ∑XNo Specify: White Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Own Home Homemaker Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I Joseph M. Buffington ပ Sarah Reed and № 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 1600 Carsins Run Road Aberdeen, Maryland 21001 Mr. Mark A. Gavis (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Ht. of Jesus Cem. 12/18/2009 21. Signature of June al Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fibrillation AtriaL /Medical Due to (or as a consequence of) Examiner Metastasis WITH Cancer una Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12-15-2009 062373 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Balto Md 21237 Robert 9000 FRANKLIN SQUARE 2

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's

**Physicia** /Medic Examin

	For State	State of Marylan				Mental Hy	giene	200	10 1	01.1.2
	Registrar		Certifi	cate of D	eath	La Data de	Reg. No.	200	75 6	10446
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Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married	12. Was Decedent Ever in U. Armed Forces? 1 — Yes 2 X No If Yes, Give Year or Dates:		Decedent of His , specify Cubar es <b>%</b> No	spanic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	i	Black,	American Ir White, etc. Black	
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ပ္ပ	8th grade  17. Father's Name (First, Middle, Last)		Track		18. Mother's Nam	ne (First, Middle	, Maiden	Surname)	)	
To B	Ozzie Wilson				Ophill					
	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing Ad	dress (Street a	nd Number or Ru	ral Route Numb	er, City o	r Town, Si	tate, Zip Coo	le)
	Dorothy Highsm				lle Str			), MI		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Wo	Place of Disposition remetery, crematory odlawn	Cemete	ery 12-		Bal	lto (		
	21. Signature of Funeral Service Licens	e		ne and Address	of Facility  North	March Avenue		st F,	,	1202
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edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence.  Due to for as a consequence.								
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 Ecte	opic pregnancy er (specify)			2	23d. Date Mont	of delivery h Day	Year
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Be	25. Was case referred to medical examiner?	Hospital:	,	Other	26. Place of Dea	th (Check only	one)			
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atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury N	28c. Injury Work 1 1 1Y	es 2 □ No			, 000000		
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edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occ ation and/or investion	urred at the tim gation, in my op	e, date and place inion, death occu	e, and due to the irred at the time	e cause(s) , date and	and man place, an	ner as state nd due to the	d. cause(s)
Ź	29b. Signature and title of certifier	of ru	)	29c. License	number		12-1	5-6	(Month, Day,	Year)
	30. Name and address of person who could be supported by the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the suppo	mont, rus	232		ears	s+:	Bo	1+	NU	21224
e	31. Date filed (Month, Day, Year)	32. Begistrar's Signa		A 6						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ET ANNA 3:30 2009 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death MENICAL ALTIMORE MORE (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🙀 M 2 🗆 F Months Hours Min. Yrs 79 Director -19-1930 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral items 23a 1410 E. Baltimore Street 21231 USA hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 X Married 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates than "natural", Specify: 3 Widowed 4 Divorced Black Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within 72 Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Hospital Addiction Counselor 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fred Hanna, Pearl Graham traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Alfreda Hanna-Wife 1410 E. Baltimore Street Balto, MD 21231 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Crownsville Vet 12-21-09 Crownsville, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility March East F/H any 4 0 CL Ε. North Avenue Balto 21202 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown 9 I Unknown P.O. I sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) -2 🔽 No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

30. Name and address

of death (Item 23a) (Type.

. Registrar's Sig

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 SCACANIO 32. Registrar's Sig

29c. License number

DO017679

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10, Elizabeth Horner December 2009 3:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Villa Rosa Nursing Home Prince Georges Bowie If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 18, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 216-14-8722 86 ME Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exaction at the redified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Egdewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 87 Stewart Drive #318 21037 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: \$ Specify: White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward F. McPhail Grace Danner ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Mr. Willis E. Horner/Son 421 Hamlet Club Drive #202 Edgwater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 and Department of He Important: If iten any injury or oth ODGE. 20a. Method of Disposition December 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 14, 2009 Elkridge, MD Meadowridge Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Mon21 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician m K1 UNI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner UARNI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the functeral director, page? Should be detached for use as the burish-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1∐Yes 2∐No 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur 12-11-2009 2261  $\gamma_{\mathcal{O}}$ who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 8116 Good Lock Richard OEC 18 2009 31. Date filed (Month, 32. Registrar's Signature State Registrar

Dec 10,2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16,2009 December Betty Lee Henry 8:00 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore County Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min (Month, Day, Director 213-30-1822 77 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore County 1 ☐ Yes 2 ☒ No Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1450 Burton Ave. 21093 United States or items 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. If Health and Mental Hygiene. If them 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2፟█ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Edward Henry Annie Priscilla Carver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Edward Franklin Henry (Son) 239 Alymer Court Westminster, Maryland Page 1 and 2 21157 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) c. 21, 2009 Dec Dulaney Valley Mem. 4 Donation 5 Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr
2325 York Road Timonium, Maryland 21093 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Cause (Disease or linjury Due to for as a consecuence of for use as the burial-transi us ceruncate has been signed by the attending physician and director, page 2 should be detached for neal mander. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗆 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) this HOSPICE completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 🗶 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

**JACKIE** 

31. Date filed (Month, Day, Year)

JONES,

8

CRNP

8:00 р.ш.

DECEMBER

HENRY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 19b, perFH, G898, 12/18/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Maxie Howlett 2009 16, 11:20A Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Nursing Home Baltimore Cockeysville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6-17-1909 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĂF 218-36-9363 TN **Director** 100 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Malfael Executed that the Indited at once. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No Cockeysville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road, Rm. # 237 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ State of Maryland State Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Kirby Smith Howlett Mary Maxwell Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14134 Wilber Robin Evans - Niece  $_{ t Mill}$ Rd., West Friendship, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12-17-09 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any trading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physiclan: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Howlett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Year arlene Halbia 0805AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Marcul and **Funeral** Months Days Hours Director 214-72-1324 53 1956 Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Glenwood Street #519 21401 Examiner must USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4X Divorced Specify: white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d other than " Elementary/Seconday (0-12) cab company dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amanda Jane Bowlin William Boswell 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1974 Mill Creek Road Raven, VA 24639 Shelly Lester/niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Important: It any injury or 4 Donation & Other (Specify) in state Signa urc of Funeral Sew LONA ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) 6 100d Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncernying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Sepsis Completed 1 Yes 2 No 3 Probably 4 Unknown Advanced liver disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sohrabi 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

TO ZUUS

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1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 🗆 No 1 ☐ Yes 1 □ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760

Examiner Hospital or Attending Physician: The law requires that the death certificate be exect attending physician for use as the buria Physician/Medical the been signed by should be detact ģ Completed has certificate filled in by the funeral director, Be Certification: To After this within 24 hours after deatl To the Funeral Director: Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

**Director** 

show

Department of Health and Mental Hygiene, important; or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It whedical Examinar must be notified at once.

1 and 2 should be 1 Health and Mental

Pages 1

**Physician** 

/Medical

Examiner

Maryland 21215-0036

Baltimore,

5

State Registrar

29c. License number MO

069529

29d. Date signed (Month, Day, Year) December 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN SQUARE DR Balto md 40 MD 9000 Warren

32. Registrar's Signature

31. Date filed (Month, Day, Year)

(Check only

29b. Signature and title of certifier

09-09673	
Joe Jordan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

e Jordan		State of Maryland / De 1-For State	Certificate of			L 0 0	9 4045
. Physicia		Registrar  1. Decedent's Name (First, Middle,Last)			Reg. 2. Date of Death		3. Time of Death
edical Exami		Joe	Jordan		Month December 1		1830 hrs
		Facility Name (if not institution, give street and number)     Harbor Hospital Center	41	b. City, Town, or Location of Deat Baltimore	n	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday)	If Under 1 Year If Under 24Hr		(MM/DD/YYYY) 9. Birth Foreign	
Director		217-29-1989 _{1XM 2} F	19 Yrs.	Months Days Hours Mir	7-23		ntry) MD
ŕ		Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Location	on			10d. Inside City Limits
how a	اِ	MD N/A B	altimore	9			1 X Yes 2 No
farylar 28a-f s	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
3a or 3		3444 Spellman		21225		U S A	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in Armed Forces?	n U.S. 13. Was	Decedent of Hispanic Origin? ( 5 es, specify Cuban, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
ter dea		1 Yes 2 X N 3 Widowed 4 Divorced If Yes, Give Year	10	Yes 2 X No specify:		Specify:	Black
ours af atural camin	d by	15. Decedent's Education (Specify only highest grade completed	during mo	's Usual Occupation (Give kind of ost of working life. DO NOT use re		6b. Kind of Business/Ir	ndustry
6 n 72 h an "n ical Ex	olete	Elementary/Secondary (0-12) College (1-4 or 5+) n	a	nployed	ured)	IIm amm 1 a	
-000 d withing giene.	Completed	12th grade   17. Father's Name (First, Middle, Last)	onen		ne (First, Middle, Ma	Unemplo	yeu
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be	Joe Lee Jordan, Jr		Tamela	Gregg		Articles (11 top)
O 21 should nd Me is ma	٩	19a. Informant's Name/Relationship (Type, Print )	- 1	Address (Street and Number or			Zip Code)
and 2 sho ealth and lem 27 is traumati		Joe Lee Jordan, Jr-Fath  20a. Method of Disposition		Ilchester Av	enue B	alto, MD 20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iten		1 X Burial 2 Cremation 3 Removal from State	crematory or oth		_19_09	Lansdown,	Md
altin nit. P. partme portan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			March Ea		110
Der <b>Q</b>		Glady Ware	ز	1101 E. Nort	h Avenu	e Balto,	MD 21202
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.			or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Cardiome all Due to (or as a consequent)		ating obesity			Dod.ii
		Sequentially list conditions, b.					
	nine	if any, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause c.	ice of):				
nsit ed L	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequen	ice of):		•	·	
0, be executed sixial and burial - transic	ical	X UNPENDED AMENDED 22 2 2	7ME CS	899 1/ <u>28/10 TT</u>			
760, cate be physic he bur	Physician/Medical	IF FEMALE: 23c. If yes, outcome of				23d. Date of delivery	
Sox 6876 leath certificate e attending phy for use as the b	cian	23b. Was decedent pregnant in the past 12 months?	of dooth	tal death 3 Ectopic preg ner (Specify)	nancy	Month [	Day Year
Box e death c the atten	hysi	1 Yes 2 No 9 Unknown 9 Unknown				<u> </u>	
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	by P	Part II. Other significant conditions contributing to death but it	not resulting in the u	inderlying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Prol	
rds, requires been sig hould be	eted				24a. Was a		topsy findings available completion of cause of
of Vital Records, ig Physician: The law requirenthis certificate has been someral director, page 2 should	Completed		<u> </u>		autops perforr	ned? death?	
tal Recian: The	a	25. Was case referred to medical		26.Place of Death (Chec			
Vita hysicia this ce	To B	Tes 2 No	2 ER/Outpatient			Residence 6 Othe	r:
– ≛ਾਵ∣	:uo	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
Division tal or Attendi rs after death. at Director; //	icati	2 Accident Investigation 28e. Place of Injury -	At home, farm, stree	et, factory, office building, etc.	28f. Location (St	treet and Number or Ru	ral Route Number, City
Division of Vital I Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificity filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)			or Town, St	ate)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knoone) Medical Examiner: On the basis of examination					
To th To th	Medical	one)  2 Medical Examiner: On the basis of examinate and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
	_	and 1-k		O.C.M.E.		December 13, 2	009
17		30. Name and address of person no completed cause of death					
Oto		Jack Titus MD. Deputy Chief Medical Exam		nn Street, Baltimore, MD	21201		
St Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Str	gnature.	w. D			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ GIUAM 204 010730 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth
(Month, Day, Year)
Tune 14,1944 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 17€XM 2 | F Director 65 200-34-6415 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11812 Randy Lane 20708 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. o. à 1 Never Married 24 Married Baltimore, Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst 12th 5+Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Joseph Johnson, Jr. Dorothy Erford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Wentworth Johnson/wife 11812 Randy Lane, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Dec. 14, Holy Trinity Cem. Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee J. Ken Sila M01053 313 Talbott Ave., Laurel, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cute 1 cuke min Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the bunial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 1 🗌 Yes 2 No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 17 No မ After this

Division of Vital

1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 1 Tyes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12/11/09 065272 RS Suite 300

29d. Date signed (Month, Day, Year)

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Day, Ye State Registrar

only one 29b. Signatur

Certificate:

Medical

32. Registrar's Signature

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** James Howard Johnson, 6:55 10.2009 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Homewood N/A Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Days Year) 213-36 - 7141 1**∑** M 2□ F 70 2,1939 Director August Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Director 1 XYes 2 ☐ No ME N/ABaltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2017 E. Lafayette Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █\No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed XXDivorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Il Hygiene. University of MD Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Housekeeper Hospital permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Harry Atkinson Lula Crenshaw 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Johnson/ Son 1010 W. Baltimore St.#902 Balt., MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury o King Memorial Park 12/16/09 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licenses 4210 Belair Road Baltimore, MD 21206 arvo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 s autopsy performed? Yes 2. No certificate Division of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed Month, Day, Year) 29b. Signature and title of certifie mwoods Road. 30. Name and addr who completed cause of death (Item 23a) (Type Print) 31. Date filed (Month, Day, Year) State 18 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ 6 2009 10:45ª™ Thelma Knox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1509 E. 35th Street Baltimore n/a 8. Date of Birth
(Month, Day, Year)
1-10-1950 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 □ M 2 🔀F **Director** 214-50-2484 59 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1509 E. U S 35th Street 21218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 **X** No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Disability Claims 2th grade vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Gary Jasper Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Parkhurst Way Balto, MD 21236 Barbara Knox-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk | 12-21-09 Randallstown, MD March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and D ath Immediate Cause (Final OCARDIAL INFARCITONS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed sician and burial-trans that initiated events ce of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending ph

		Due to	(or as	a con	seque	enc
L	d					
Т						

23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23d. Date of delivery Month Day

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION

HYPERCHOLESTEROLEMIA

e. Dia topaci	co us	e con	indute to the cau	se or death:
1 Yes	2 [	] No	3 Probably	4 🗌 Unknown
la. Was an		24b.	Were autopsy fin	dings available

Year

25. Was case referred to medical

1 🗆 Yes 2 🔀	No 1 🗆 Y	es 2 🗆 No
ly one)		
- 5	6 D Other (0-	-16.)

28f. Location (Street and Number or Rural Route Number,

examiner?
1 \sum Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident
3 Suicide,
4 Homicide Investigation 6 Could not be determined

IF FEMALE

23b. Was decedent pregnant

g Unknown

in the past 12 months?
1 Yes 2 No

(Month, Day, Year)	injury		wo
		M	1.0
8e. Place of Injury - At he	ome, farm, stree	t, fact	ory, office

1 Inpatient 2 ER/Outpatient 3 DOA

ıry at rk?	28d. Describe how injury occurred
Yes 2 No	

//		Sity of Yours, Ottato,
1 Certifying Physicia	an: To the best of my knowledge, death occured at the time, date and place, a	and due to the cause(s) and manner as stated.
	On the basis of examination and/or investigation, in my eninion, death accurred	

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

b.	Signature and title of certifier	
	14. 111/2 10	
	flow / ho	,
_		

29c. License number	
D00590	76

26. Place of Death (Check or

29d. Date signed (Month, Day, Year)	
12/18/2009	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no. Ro

	0 4	11		
ate	31. Date filed	(Manth	Day Year	2009

LIMP P . Registrar's Sign Bella

St Registra

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P.O. I

Division of Vital Records,

signed to

ate has t certificate Physician:

this

within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral or

To the Hospital or Attending

Completed by

Be

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Certificate:

Medical

29a. Certifier (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For Amend Items 25,27,28a Fred me,8 Registrar Ce	858 912 918 955 Ginbo	rientai Hygie Reg	N2009 40454							
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Mary Louise Kellum		2. Date of Death  Month  December 9	3. Time of Death							
ر ا	Examin		4a. Facility Name (if not institution, give street and number) 3039 Fleetwood Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Death							
	Funeral Director		5. Social Security Number 212–32–4243  6. Sex 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Mary Tand							
	Maryland 28a-f show etified at	rector	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 ☐ No							
	with the 23a or 3ust be no	Funeral Director	10e. Street and Number 3039 Fleetwood Avenue	10f. Zip Code 21214	10g	g. Citizen of What Country?							
9800	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	by	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. White Specify:							
Baltimore, Maryland 21215-0036	vithin 72 hor iene. r than "nat the Medica	Completed	(Specify only highest grade completed) I (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) THEMBIKEY	ng	b. Kind of Business Industry <b>In Home</b>							
yland 2	should be filed v n and Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last)  James Lee Ward	18. Mother's Name Nora Els	e (First, Middle, Maio S <b>ner</b>	den Surname)							
, Mar	0 = 1		John D. Kellum, Sr. / Husband 19b. Mail 303	ing Address (Street and Number or Rura 9 Fleetwood Avenue Ba.	l Route Number, Cit Itimore Mar	ty or Town, State Zin Code) y Land 21214							
timore	permit. Page 1 and in Department of Healt Important: If item any injury or other once.		20a. Method of Disposition  1  Burial 2 XI Cremation 3  Removal from State 4  Donation 5  Other (Specify)	osition (Name of maton or other place) er VICE COPp. 12/11,	/09	c. Location - City or Town, State Towson Maryland							
Ball	permit Depart Impor any in			2. Name and Address of Facility _eonard J. Ruck, Inc.	5305 Ha Baltimo	arford Road ore Maryland 21214							
	Pnysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest,	Approximate Interval Between Onset and Death							
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	ecuted and transit	Examiner	Triany, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of):	ine Care	APPROVED BY MEDIC	CALEXAMINER							
09	icate be executed g physician and s the burial-transit	edical E	d	CERTIFICATION									
Box 68760	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p, completed filled in by the funeral director, page 2 should be detached for use as:										☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	uires that th n signed by ald be detad	by	Part II. Other significant conditions contributing to death but not resulting in the PROGLESSIVE SUPLANICEME OPPOSITION HEMATOMA			cco use contribute to the cause of death?							
Division of Vital Records,	The law req ate has bee page 2 shou	Completed	SUBBURN HEMATOMA		24a. Was an autopsy performer								
Vital	ysician: is certific director,		25. Was case referred to medical examiner?  1 ☑ Yes 2 ☑ No Hospital:  1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Checkent 3 DOA Other:		e 6 ☐ Other (Specify)							
on of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Certificate:	27. Manner of Death  1 Natural 5 ☐ Pending 2 A Accident Investigation  28a. Date of injury (Month, Day, Year)  1 Natural 5 ☐ Pending 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	of 28c. Injury at ***********************************	28d. Describe how i								
Divisi	ial or Atters of all Directors all Directors ad in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) Unknown		28f. Location (Stree City of Town, S	t and Number or Rural Route Number, tate) <b>Unknown</b>							
	he Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check (Check only one) 1	stigation, in my opinion, death occurred at	the time, date and p	lace, and due to the cause(s) and manner stated.							
	To t with To t		29b. Signature and title of certifier  According to the signature and title of certifier	29c. License number  Doo ZSo 10	29d	Date signed (Month, Day, Year)							
)			30. Name and address of person who completed cause of death (Item 23a) (Type, 56x6WA R. NOCAN MS 8831 SATYR 64	Print) Le Ro # 100 BACFI.	nolo, No	21234							
	Stat Registra	te ar	29c. License number  Doo 25010  December 7, 2009  O. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SERENA R. NOCON INS 8831 SATYR HILL RO #100  BALSIMORO, NO 2123 4  1. Date filed (Month, Day, Year)  DEC 18 2009  A. Registrar's Signature  DEC 18 2009										

09-09751 Theresa Mae Kir	ng	Please Type or Print in Black Inde State of Maryland / Departr	ment of	Health ar					009	3 4045
∝ Physicia Medical Examir		1- For State Registrar  1. Decedent's Name (First, Middle,Last)  Theresa	Mag.				Date of De	Reg. No.	ear	3. Time of Death
Medical Examin		4a. Facility Name (if not institution, give street and number)		King b. City, Town, o	or Location o		Jecemb		ty of Death	
/		1770 Mentpelier Street Union Memorial Hosp		Baltimore	- Figure 1	- 04U I	. D		0.00	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I	• •	If Under 1 Ye  Months Day		3.4		9-1963	Foreig	thplace (State or gn untry) MD
		Usual Residence of Decedent	Yrs.				<u> </u>	J-1700		unity) PID
nd Show any	_	10a. State 10b. County 10c. City, Town	vn or Locati							10d. Inside City Limits 1 Yes 2 No
be Maryla or 28a-f	Director	10e. Street and Number 1779 Montpelier Street		10f. Zip Code 2 1	218			10g. Citizen of	What Cou	ntry?
ath with the tems 23a st be noti	Funeral [	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XX No.		s Decedent of H es, specify Cuba				No- 14. Re		ican Indian, Black,
s after des ral", or i	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 N				Specif	γ.	slack
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th grade  16  College (1-4 or 5+)  na	during mo	ts Usual Occupa ost of working life isable	e. DO NOT			16b. Kind of	isab	ŕ
15-0036 filed within 7 al Hygiene. ed other than	Be Com	17. Father's Name (First, Middle, Last) Ross King			18.Mother	,		l , Maiden Surna liams		
2121 ould be fi. i Mental Is marked ic event,	To B		19b. Mailing	Address (Stre				umber, City or T	own, State	, Zip Code)
MD nd 2 sho alth and m 27 is		Rosemary Green-Sister		Montp						ID 21218
Baltimore, permit. Pages I an Department of Hea Important: If iten		20a. Method of Disposition  1	atory or oth	tion (Name of co er place) Cemet	,		22-0	9 Lans		
Salti ermit. epartm mports ijury o		21. Signature of Funeral Service Licensee	22. N	ame and Addres		racal	ch E	ast F/	H	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do	not enter th	1101 E					lto,	MD 21202 Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic								Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
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760, ficate be g physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnant	су		-				of deliver	•
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Physician/Medical	past 12 months?  1 Yes 2 No 9 V Unknown  1 Unknown	-=	al death 3 ner (Specify)	Ectopic	pregnanc		Month	ı .	Day Year
O. E hat the ded by the etached		Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause	given in Pa	art I.	23e. Did	tobacco use co	ntribute to	the cause of death?
S, P.	ed by			-	_		_	es 2 ✔ No		
ord: aw requas been as been 2 should	Completed							opsy		utopsy findings available completion of cause of
Rec The l	Con			_			1 Yes	formed?	1 Y	es 2 No
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ion trendin leath. tor: A	atior	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)		1	Yes 2	No				
Division of Vital Records, tal or Attending Physician: The law requirers after death.  The law require is after death.  The law require has been similar to be the sector. After this certificate has been similar in by the funeral director, page 2 should be the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)	, farm, stree	t, factory, office	building, et	c. 28	f. Location or Town		nber or Ru	ural Route Number, City
ne Hospi n 24 hou ne Funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/o	death occur	ed at the time, o	date and pla	ace, and du	e to the ca	use(s) and man	ner as stat	ed.
To tl withi To tl	Medical	29b. Signature and title of certifier	vestiyati		se number	our ou at If	- mie, ua			nth, Day, Year)
	_				.M.E.			Decemb		
OCME		30. Name and address of person who completed cause of death (Item 23a	,			1.041				···
$\emptyset$		Mary G. Ripple MD. Deputy Chief Medical Examin	er 111	Penn Stree	et, Baltim	ore, MD	21201			
Sta	ite	31. Date filed (Month, Day, Year)  32. Registrar's Signature								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otato of W	ar y larra		rtificate of		Wientarry	Reg. No.	1114	40456
	Physici	an	1. Decedent's Name (First, Midd					-	2. Date of De	D	Year	3. Time of Death
	/Medi	cal		rt James Kea	ting			<del> </del>	Decem		7 2009	2:20 A.M.
and of	ි Examir	ier	4a. Facility Name (If not institution	,	1 Com	h		r Location of Dea	ath		County of Dea	
	Funeral		Baltimore Washi 5. Social Security Number	6. Sex 7. Ag	e (In yrs. las		If Under 1 Year				Anne Ar	rthplace (State or Foreign
L	Director		335-14-7210	1 X M 2 □ F	84	Yrs.	Months Days	Hours Mir	01-29-			lainois
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation	<u></u>				10d. Inside City Limits
	a-fsh	ctor	MD Anne	Arunde1			0 <b>de</b> 1	nton				1 □Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	s 23a	eral	715 Dayspring				2111				ited St	ates
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in after Evarinar must be notified anone.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3X Widowed 4 ☐ Divorced	ried 12. Was Decedent Armed Forces? 1 Types 2 1 If Tes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba 1 □Yes 2 M No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whit Specify:	te, etc.
2-0	72 hor	eted	15. Deceder	t's Education st grade completed)	1	I6a. Deced	dent's Usual Occup	ation	orking	16b. Kin	nd of Business	hite /Industry
21215-0036	vithin ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done OO NOT use retired		orking			_
	filed v Hygie other t	ပ္ပိ	12 17. Father's Name (First, Middle,	Last)		Manpo	wer Engi		me (First, Middle		S. Air	Force
Maryland	Jid be Jental rked c	To Be	John D. Kea	ing					Ruth Kel		,	
lar,	2 shou and h is ma auma	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street				Town, State,	Zip Code)
	is 1 and 2: of Health a item 27 is other trau		Vonda Chaney /	Daughter			ayspring	Drive C				
Baltimore,	Pages thent of tant: If ite		20a. Method of Disposition  1 XI Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cem	etery, cren Ouan i	sition (Name of natory or other place tico Cemetery	12 <b>-</b>	Date 14-2009		cation - City or $ one 1e$ ,	Virginia
Bai	permit Depar Impor any in		21. Signature of Juneral Service	Olduns	es		Name and Addre Oonaldson 411 Anna	Funeral polis Ro	Home & ad Odent	Crema	atory, Maryla	P.A. nd 21113
			23a. Part 1. Eliter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. I	Do not ente	er the mode of dyir	ig, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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9	artificat ing phy as the	Medical		0.	17	1.000	110.0					
O. Box	ath ce	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 🗌 Fetal de	ath 3	Ectopic pregnance Other (specify)	/		23	3d. Date of de Month	elivery Day Year
σ,	uires that the de signed by the a d be detached fo		Part II. Other significant condition	ns contributing to death bu	it not resultin	g in the un	derlying cause give	en in Part I.	23e. Did to	obacco us	e contribute to	o the cause of death?
ords	w requires been sig should be	ted by							101	res 2	No 3□P	robably 4 🗍 Unknown
Vital Records,	slcian; The law certificate has b rector, page 2 sh	Completed							24a. Was autop perfo 1 □ Yes	sv	prior to death?	utopsy findings available completion of cause of
7	s certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			Othe	ar.	ath <i>(Check only</i> o			
ō	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	v 28	b. Time of	t 3 ☐ DOA Othe 28c. injury Work	4 LI Nursing I	Home 5 Resident			ecify)
Sio	endin eath. or: Af he fur	atio	Natural 5 Pendin investig	ation	, rear)	Injury		:? Yes 2 □ No				
Division of	tal or Att rs after d al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ry - At home, . <i>(Specify)</i>	, farm, stre	et, factory, office	112.	28f. Location (5 City or Tov	Street and vn, State)	Number or Ru	ural Route Number,
	he Hosp in 24 hou he Funer pletely fil	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
	To t	Ž	29b. Signature and title of certifier	. 44			29c. License			^	signed (Mont	
	141		Madan	MO			12 43	7//		the	mber	9 2009
-	2 V		30 Name and a dress of person	who completed cause of de	eath (Item 23	a) (Type, F	me, [	en Bin	me.	7776	20/0/	· .
	Stat		31. Date filed (Month, Day, Year)	32. Registra	r's chature	bank	2	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~		.,,,,	- 1001	
	Registra	17	LILLU 25 9 60	IN ASSESSED TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE	1 12	7						

DHMH 17 Rev 1/2001

			For State	State of Ma	aryland					nd Me	ental Hyg	giene		
_			Registrar  1. Decedent's Name (First, Middle,	l anti		Cer	tificate	of De	eath			Reg. No.	2009	40457
	Physicia Medic			Ethe1	D.		Кс	oug1			2. Date of Dea Month Decembe	Day	4, 2009	3. Time of Death 9:30P M
	Examir	ner	4a. Facility Name (if not institution,	-			4b. City, To		ocation of	Death			County of Death	
	Francis		Riverview Nurs  5. Social Security Number		(În yrs. last	hirthday)	Es If Under 1	SSex Year II	If Under 2	4 Hrs o	, Date of Birth		Baltimo:	re Co. hplace (State or Foreign
	Funeral Director		212-16-3390	1 □ M 2 🔯 F 9		Yrs.			Hours		(Month, Day, Sept.	Year) 8,19	19 Ma	intry) ryland
	ind show at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Loc	ation	_		-				10d. Inside City Limits
	Maryla 28a-f ş otified	Funeral Director	MD IN B	altimore			Dur	nda1k	k					1 🗌 Yes 2 🖾 No
	h the la or 2 be no	a Di	10e. Street and Number				10f. Zip C	Code				10g. Citi:	zen of What Cou	untry?
	th with ms 23 must	ner	1906 Willow S						1222			Uni	ted Sta	tes
21215-0036	's after dea ral'', or iter Examiner	Completed by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marries</li><li>3 ☑ Widowed 4 ☐ Divorced</li></ul>	12. Was Decedent Ev Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates.			Vas Deceder Yes, specify			in? (Specif Puerto Ric	y Yes or No- can, etc.)		14. Race - Amer Black, White Specify: W	
5-0	2 hou "natu edical	plet	15. Decedent (Specify only highes			(Give k	ent's Usual (	done duri		of working			nd of Business I	ndustry
121	ithin 7 ene. r than	Som	Elementary/Seconday (0-12) 12 Years	College (1-4 or 5+ 5 Years	-)	life. DC	NOT use re eachei	etired)					ltimore ublic So	-
DQ 2	illed will Hygi	Be	17. Father's Name (First, Middle, La		-		eache.	1	8. Mother	's Name (F	First, Middle, N			
ylar	ld be f Menta arked atic e	욘	Anthony Dace	ewicz						Jea	nette	Mar	chlewsk:	i
, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi  Kathleen M. Ko		r)	19b. Mailin 190	g Address (S <b>Will</b>	Street and OW S	Number Sprin	or Rural R g Roa	oute Number, ad Dur	City or I nda1l	Town, State, Zip k, Mary	Code) land 21222
Baltimore,		(8.5)	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		cem	neterv. crem	sition (Name latory or othe SS Pol	er place)	Nat.	Dat 12/1			cation - City or I undalk,	Town, State Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Li	censee									ndalk, i vland 2	
	Physician/ Medical Examiner	ər	23a. Part 1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,		5CL consequen	<i>ELO</i> ?	TIC C						EASE	Approximate Interval Between Onset and Death
\$09 	or Attending Physician; The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. MAL/ Due to (or as a decorated of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contr	VU7 consequen	Ce of):	0~							
876	ificate ng phy as the		IF FEMALE:											
. Box 687	hat the death certifics ed by the attending p detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome o' 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal de	eath 3 🗌	Ectopic pre Other (spec			-		2	23d. Date of deli Month	very Day Year
ls, P.O.	w requires that th s been signed by should be detac	ed by Pł	Part II. Other significant condition	s contributing to death but	t not resulti	ng in the ur	nderlying cau	use given	in Part I.		111		se contribute to	the cause of death?
Division of Vital Records,	sician; The law req certificate has bee irector, page 2 sho	Somplet								_	24a. Was ar autops perforr	sy	prior to co death?	opsy findings available ompletion of cause of
tal	iysician; is certific director,	Be	25. Was case referred to medical examiner?	Lioppitals				1	of Death	Check on				
fΝ	Physic this cal dire	2	1 Yes 2 No	Hospital:									Other (Specif	5)
0 4	ding I th. After funer	cate	1 Latural 5 Pending 2 Accident Investiga		Year)	b. Time of injury	м 28с	. Injury at work?	t s 2 □ N	- 1	l. Describe ho	w injury	occurred	
Divisio	al or Atten s after dea I Director: d in by the	Certificate:	3 Suicide 6 Could not determine	ot be		e, farm, stre	_				Location (Str City or Town		Number or Rura	al Route Number,
_	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 <u></u> Medical Ex	Physician: To the best of maminer: On the basis of exa Nurse Practioner: To the basis	amination an	nd/or investi	gation, in my	opinion, o	death occi	urred at the	e time, date an	d place, a	and due to the ca	ause(s) and manner stated
	To t		29b. Signature and title of certifier	1 16 Tul	lce	MD	29c. L	icense nu	umber 188	-	2	9d. Date	e signed (Month,	Day, Year)
	10		30. Name and address of person w	no completed cause of dea	ath (Item 23	sa) (Type, Pr Ma	rllel-	PK	a	Du	dalle	M	e signed (Month, -15-0 10 21	222
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	all	,							

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 20069 Charles King 5:50 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7232 German Hill Road Baltimore Baltimore 8. Date of Birth (Month, Day, Year) Apr 29, 19 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 213-62-2244 Director 55 1954 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Invalid Examination and injury or other traumatic event, the Invalid Examination and injury or other traumatic event, the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Invalid of the Director 1 ☐ Yes 2√☐ No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7232 German Hill Road 21222 Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📆 No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Heritage Nursing Ctr 7232 German Hill Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5 Nother (Specify) in state 21. Signature Funeral Service License Ronald S 22. Name and Address of Facility State Anatomy Baltimore, MD 655 W. Baltimore Street 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Suse (Final disease or constition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 TYPS 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RUC 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? 2 **1** No 1 ☐ Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Latural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 ☐ Could not be determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records,

3altimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

nd title of certifier 29b. Signature

TO SOU?

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2009 1.00 174 Latona ami /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4 Rehal 20707 Itealth MIK KIUTT Laure If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Haiti Social Security Number 6. Sex 7. Age (In yrş. last birthday, **Funeral** Months Hours 6-6968 Days 1□ M 2 F Director Usual Residence of Decedent should be filed withIn 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐Yes 2 K No r items 23a or 28a-f shiner must be notified. **Funeral Director** Laurel Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14200 Laurel Park Drive 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Black <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Madical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care 2 Nurses Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F unknown unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is Marcelle Desroches /friend 8303 Honey Hill Road, Laurel, Maryland 20707 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important: If i = 5 Dec 16, 09 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part 1. Enter the As ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. mmediate Cause (Final CANCER (INDPERABLE 0 N **Physician** OL YEAD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -3 WEEK PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ON EL TUS 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No. 24a. Was an GLNTE performed? Yes 2 No DEMENTIA VASCULAR 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) ATTENDING 29c. License number 29b. Signature and title of certifier mon ex mo 20057216 DEC 14, 2009 PHYSICIAN

State Registrar 31. Date filed (Month, Day, Year)
DEC 18 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL BAAKO, MD, 345B FORT MEADE AD, #209, LAURE

#### State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Ethel S. Lang Dec 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Towson Pickersgill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 X Min Nov. 25 1917 Month: Days Hours MD try) 92 Director 216-05-8315 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Completed by Funeral Director must be notified MD **Baltimore** Towson 28a-f ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 615 Chestnut Ave. 21204 and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ral", or iten Examiner Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12 Homemaker n/a Be ( 27 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jerome J. Stinefelt Myrtle E. Wiegel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10512 Pot Spring Rd., Cockeysville, MD 21030 Edward J. Lang/son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jessops Cemetery 12/19/09 Cockeysville, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21 Signature uneral Service Light Bryan 23a. Part 1. F er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, / r heart ailure. List only one cause on ead line. Immediate ause (Final disease or ondition resulting in hysician/ Medical **Examiner**

attending physician for use as the buria Division of Vital Records, P.O. Box 68760

Completed by Physician/Medical Examiner Medical Certificate: To Be

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HALVES

W

32. Registrar's Signature

PERMINA	Due to (or as a consequence of).				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of):				
that initiated events resulting in death) Last	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 W No 9  Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year		
	stributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
ischemic cardi	myopathy cues revascular	1 🗆 Yes 2	Yes 2 No 3 Probably 4 Unknown		
discase, deme	ation	24a. Was an autopsy performed? 1 □ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No		
25. Was case referred to medical	26. Place of Death (Chec	k only one)			
examiner? 1  Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🕍 Nursing H	ome 5 🗆 Residence	6 Other (Specify)		
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street al City or Town, State	nd Number or Rural Route Number, e)		
(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, date and place, a er: On the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and plac	e, and due to the cause(s) and manner stated.		

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

40460

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

100

29d, Date signed (Month, Day, Year,

NOCONOT

16.2009

white

1 Yes 2 No

10:57 p^M

State Registrar

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

To the

09-09737	
David Lovin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

VIG LOVIN		1- For State Criticate of Maryland / Department of			200	9 4046	
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death	
edical Exami	ner	David M. Lovin	o. City, Town, or Location of Death	December	14, 2009 4c. County of Death	2100 hrs	
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	Baltimore		4c. County of Death		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Birt		
Director		219-98-5250 1 M 2 F 27 Yrs.	Months Days Hours Min.	4-12-	1982 co	untry) MD	
ý		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on.			10d. Inside City Limits	
J 10 w an		MD Baltimore Baltimor				1 Yes 2 X No	
aryland 8a-f sh at onc	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?	
more, MD 21215-0036 Pages 1 and 2 should be filted within 72 hours after death with the Maryland tent of Health and Mental Higene. Inti. If time 27 is marked other than "natural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner must be notified at once.		7703 Wynbrook Road	21224		USA		
th with ems 23 t be no	Funeral		Decedent of Hispanic Origin? ( Ses, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,	
er dear or it		1   Yes 2   ANO	Yes 2 X No specify:		Specify: Wit	nite	
ours aft tural' amine	d by	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's	's Usual Occupation (Give kind of est of working life. DO NOT use ret	work done	16b. Kind of Business/I	ndustry	
imore, MD 21215-0036  Pages I and 2 should be filted within 72 hours after death with ment of the flath and should be filted within 72 hours after death with antifficing 77 is marked other than "natural", or items or other tranmatic event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	isabled	iled)	Disable	a l	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ome	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M			
215 be filec ntal Hy rked ol	ВеС	Weith D. Mangue		L. Lov			
21 hould nd Mei is mai	욘	Dorconall	Address (Street and Number or				
and 2 s ealth a em 27 rem 27	/ X	Thomas U. O Nett-Rep. 1/703  20a. Method of Disposition 20b. Place of Disposi	Wynbrook Roation (Name of cemetery,	Date	20c. Location - City or	Town, State	
NOFE ages 1 at of H t: If it		1 Burial 2 X Cremation 3 Removal from State crematory or oth	Crematory 12	-18-09	  Baltimor	e, MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Inportant: If item 27 is marked other tu injury or other traumatic event, the Med		4 Donation 5 Other Specify: Bayview 21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility Br	adlev-	Ashton Fu	neral Home	
Per Per in		PA	. 2134 Willow	Spring	Road, 2	1 2 2 2 Approximate Interval	
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		or respiratory arre	st, snock, or near	Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Alcohol and narcot  Due to (or as a consequence of):	ic intoxication			<del> </del>	
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate Due to (or as a consequence of):					
N B E	xan	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Medical	d. AMENDED 22 DTI 27 29		1/20/10	mm		
Box 68760, death certificate be ne attending physicid for use as the buri		IF FEMALE: 23c. If yes, outcome of pregnancy	a-f,permE, g899	1/20/10	23d. Date of deliver		
Box 687 death certific the attending p	Physician/	past 12 months?	tal death 3Ectopic pregr her (Specify)	nancy	Month	Day Year	
Box death the atte	nysic	1 Yes 2 No 9 Unknown 9 Unknown			v -		
P.O. s that the gned by t	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		bbacco use contribute to		
4S, F quires en sign		Cirrhosis of liver		24a. Was	an 24b. Were a	utopsy findings available	
cords, law requir has been s	Completed				rmed? death?	completion of cause of	
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Chec	1 Yes	2 No 1 1	es 2 No	
Vital ysician his cert directo	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient	I Other		Residence 6 Oth	er:	
Division of Vital Records, tal or Attending Physician: The law requires after death.  Director: After this certificate has been seled in by the funeral director, page 2 should?	l ⊢	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of I		1 .	how injury occurred		
ivision or Attendi after death Director:	jatio	Natural 5 Pending Investigation Fd 12/14/09 Fd 8:24 28e. Place of Injury - At home, farm, stree	4 pm 1 Yes 2 X No	unk	Street and Number or R	rural Route Number City	
Divis pital or A ours after teral Dire	Certification:	Suicide OA Could not be determined (Specify) Ed private du		Baltimo	State) 4111 E.	Lural Route Number, City Lombard St	
프로 등 글:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, ar	nd due to the cau	se(s) and manner as sta	ated.	
To the Hos within 24 h To the Fur completely	edica	Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated					
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M December 16, 2		
d		20. Name and address of passes who appropriate against death (from 22c)	O.O.IVI.E.		3000111001 10, 2		
$\psi$		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD	et, Baltimore, MD 21201				
	tate	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,				
Regi	strai	and to those to the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 A M December 7:17 William Daniel Ladany Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Davs Hours Min. June 21, 1929 Pennsylvania 80 187-20-8292 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20906 15311 Beaverbrook Court, #1F United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. rmed Forces?

X Yes 2 \( \square\) No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Korea Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Comptroller Laundry of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gabor Ladany Sofia Lazarik permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethelene Theresa Ladany / Wife Silver Spring, MD 20906 15311 Beaverbrook Court, #1F, Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 18, December 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland 21. Signature of Funeral South e Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Lung Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Gastrointestinal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ဨ 1 Yes 🛚 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 1 🔀 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Sarah Bromeland, M.D. 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3[

29b. Signature apd title of certifier

1500 Forest Glen Road, Silver Spring, Maryland 20910

29a. Certifier (Check

only one)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D62571

December 11, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 15 2009 LEVITT 2:20P M PEARL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SPRINGHOUSE ASSISTED LIVING PIKESVILLE 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1277571910 Country) NY 99 **Director** 072-18-7989 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 2210 SUGARCONE ROAD 21209 death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY COLUMBIA PICTURES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o မ SAMUEL LITTMAN IDA LEVITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 2210 SUGARCONE ROAD, BALTIMORE, MD 21209 BARRY LEVITT / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State BERTY COMMENT OF Place)
AAREI ZION CONG. 12/17/2009 | RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Atheroacleratic cardiolascular aliseas Physician/ disease or condition resulting in death) Mouths Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine rany, leading to influences, cause. Enter Underlying Cause (Disease or iinjury Due to (ar as a nonesquence of): attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperte usion No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy has 1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes hours after death.

Ineral Director: After this certific of filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one. Be ASSISTED examiner? Hospita Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my entities. Medical 29a Certifier

State Registrar 29b. Signature and title of certifler

1 amara

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sobel, UID

Registrar's Signatu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 CVOSSYOUUS Drive #410 CWINGS MILLS, WID 21117

December 16,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 6,26a, b per fh, 8898, 12/21/09dhb. Amend Item 23 17 19 Maryland Department 1981 1991 Head Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day November 30, 2009 **Physician** 12:31 AM Cormac Martin Lannon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2210 Dairy Farm Rd. Gambrills Anne Arundel 8. Date of Birth (Month, Day, May 23, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 K M 2 K Days Hours 76 Months Min. Pennsylvania 200-26-7282 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Evanimer must be notified at Director 1 ☐ Yes 2 No Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 21054 United States 2210 Dairy Farm Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 o, 1 ☐ Yes 2 ☐ No Specify <u>\$</u> Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Imp. Monce. College (1-4or 5+) Civil Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be 1 Paul Callihan Lannon Mary Eugenia Hurst မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Lannon /Son 16027 Falls Rd. Sparks , MD 21152 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Dec 02 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical CERTIFICATION APPRO IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 🗌 Unknown 9 Unknown APAPLE GIA, HYPEKTEN 23e. Did tobacco use contribute to the cause of death? Records, <u>≥</u> C Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed? Surgery for spinal cyst with complications Physician: The certificate Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð this 28a. Date of Injury (Month, Day, Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the hin 2 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) To With 2 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed AR. LINTHICOM 31. Date filed (Month, Day, Year, TFC, 18 0 Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,26 per me/dr., 2898,12/17/09dhb

Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2009 Day 04 Christopher Lee Lesher A M 8:33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Yea 5 / 18 / 197 1 🕱 M 2 🗆 F Min. Country) Director 32 217-17-7100 WV Usual Residence of Decedent 28a-f show 10b. County filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7412 Locust Drive 21076 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1XXNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify. Completed 3 Widowed 4 Divorced Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Construction Construction Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Cathy Mae Davis Gary Lee Lesher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanover, Maryland 21076 Gary L. Lesher / father 7412 Locust Drive, **Baltimore**, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Important: If any injury or 4 Donation 5 Other (Specify) 12/07/09 Atlantic Crematory Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 2nd Ave, SW Glen Burnie, MD 1 Singleton Funeral & Cremation Services, P.A. M01357 23a. Part 1. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, chear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner MEDICAL EXAMINER the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATIO physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) has been signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Other: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Sesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natura! 5 Pending injury Accident Investigation

or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. Certificate: after death. the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and erson who completed cause of death (Item 23a) (Type, Print) MEdison 32. Registrar's Signature State RENE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna 15, 2009 Mav Lee December 12:15 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Maryland Masonic Home Cockeysville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Days 1 M 2 KF Months Hours Min. 84 Feb 14, Director 219-58-6006 1925 Canada Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐Yes 2 ☐No Baltimore Director Baldwin 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 4401 Sweet Air Road 21013 "natural", or items 23a U.S.A. Completed by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Asian 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wong Doo Leung Lim 0n ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Lee-son 4901 Carroll Ct., Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 12/21/09 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fugeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pancreas Immediate Cause (Final **Physician** Cz resulting in death) /Medical Due to (or as a conseque of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 은 1 Inpatient this within 24 hours after deau..

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Redistrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3008

32. Redistrar's Signature

Bank St

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Ruth Naomi Medley 2009 1:20 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F 231-24-6944 VA 06/03/1922 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 √ Yes 2 No Montgomery Potomac 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20854-4419 10714 Potomac_Tennis Lane USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Medley <u>Lucinda Pullman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Renee Medley/Niece 350 G St. SW #N609 Washington DC 20024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/₁₈/2009 Alexandria, VA Metropolitan Crem. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Dementia Due to (or as a consequence of) Acute Renal Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Chronic Renal Insufficiency Due to (or as a consequence of): Sepsis 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anaemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy 2⊠ No Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

12 should be filed w h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 should bu Department of Health and Menta Important: If item 27 Is marked any InJury or other traumatic ev

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Exami Physician/Medical

Certification:

Medical

State Registrar

attending physician and for use as the burial-transit ned by the atter Completed by Be ပ funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4₺Nursing Home 5□ Residence 6□Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident

28a. Date of Injury 5 ☐ Pending investigation (Month, Day Year) 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

💼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

28h Time of

29c. License number D-20274

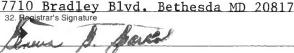
28c. Injury at Work?

29d. Date signed (Month, Day, Year) 12/14/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti K. Vohra, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature



DHMH 17 Rev 1/200

To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

09-09755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

obert K. Weade	1	1- For State Certificate of D		Reg. N	No. 2009 404	168
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month Da     December 15	3. Time of Death	
ledical Examin		ROBERT R. MEADE  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Deat		4c. County of Death	
			Clinton		Prince George's	
Funeral Director		S. Social Security Number	f Under 1 Year If Under 24Hr Months Days Hours Min		MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Kentuc.	kv
Director	-	578-48-7945   1XXM 2 F 78 Yrs.   Usual Residence of Decedent		Julie 10	, 1991 oddwy/Refrede	J. J
any	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lir	_ \
daryland 28a-f show any 1 at once.	٥	MD Prince George's Clinton			1 Yes 2XX	No
th the Maryland 23a or 28a-f sho notified at once	Director	100.00000	Of. Zip Code	,	Citizen of What Country?	
ith the		8511 Temple Hills Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	20748-5508 Decedent of Hispanic Origin? (\$		S . A .  14. Race - American Indian, Black,	ᅱ
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she aumatic event, the Medical Examiner must be notified at once	- I	1 X Never Married 2 Married Armed Forces? If Yes, 1X Yes 2 No	specify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.	
after cral", o	by F	3 Widowed 4 Divorced of Parks: Korean 1 Yes	es 2 XX No specify:  Usual Occupation (Give kind of	Ework done	Specify: White  Sb. Kind of Business/Industry	
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336 thin 72 ne. than ledical	Completed	Grade 12 Clerk			Grocery Store	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	_	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	iden Surname)	ļ
121 Id be fi fental narked event,	o Be	Joseph Meade  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing A		Dempsey Rural Route Numbe	er, City or Town, State, Zip Code)	
MD 2  id 2 shou lith and M m 27 is n aumatic	۲		ayfair Terrace	Laurel,	Maryland 20707	
G, N I and Health Fitem	1	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or other		Date 2	20c. Location - City or Town, State	
Pages nent of ant: Il	П	4 Donation 5 Other Specify: W. Arundel	Crematory 12	/18/2009	Odenton, Maryland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21. Signature of Euneral Service Licensee 22. Nar DON	aldson Funeral	Home, P.	A. , Maryland 20707	
Physician	0 10	/ M00770 313 23a. Part I. Enter the disease or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart Approximate Interpretation Between Onset	
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot Wound of Head			Death	and
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Medical Examiner	(Disease or injury that initiated consistent of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the			9	
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'Vit	70 E	1 Yes 2 No Inpatient 2 ER/Cutpatient			Residence 6 Other: Scene	
Division of Vital Records, ral or Attending Physician: The law requirers after death.  "In Director: After this certificate has been sided in by the funeral director, page 2 should be	ion:	27. Manner of Death 1 Natural 5 Pending Round: Day, Year) 1 Natural 5 Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending	1 Yes 2 ✓ No	Subject shot		
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Div pital or ours aft eral D	Certification:	4 Homicide determined (Specify) Single Family		8511 Temple F	Hills Road, Clinton, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transitions.			ed at the time, date and place, a on, in my opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
To tl	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
	-	highi. ws	O.C.M.E.		December 16, 2009	
10/		30. Name and address of person who completed cause of death (Item 23a)	Dolling - BED 04004			
10		Ling Li, MD Assistant Medical Examiner 111 Penn Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature	r, Baitimore, MD 21201			
Si Regis	tate trar		P			
DHMH 17 Rev 1/2		4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** McShane Suzanne D. December 15 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐XF 042-28-6100 78 Connecticut Director March 8, 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Mudical Examiner must be notified at 10d. Inside City Limits MD Baltimore Cockeysville Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road, Apt B1 21030 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🔣 No Specify. Specify: White ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental 7 is marked c traumatic eve Charles Walton Deeds Ruth Belden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. McShane - Spouse 13801 York Road, Apt B1, Cockeysville, Maryland 21030 27 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 cemetery, crematory or other place Evans Funeral Chapel & 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) <u>Cremetion Services Belair Dec. 17, 2009 Forest Hill, MD</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Monkton 16924 York Road, Monkton, Maryland 21111 laru 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 ☐ Yes 2 **N**O 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 I or Attending F after death. e Funeral I within 2

with the Maryland

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Marvi

Baltimore,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

DEC 18 2009

HAM(D)

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

913

32. Registrar's Signature

29c. License number

050232

MOGEBROOK RP STC 312 SPARMS MD 21152

29d. Date signed (Month Day, Year)

		•	For State Registrar		State of	waryiari		rtificate of		na ivier	,	gieri Reg. Ne		1.01.70	
ŀ	Physicia	an	1. Decedent's Name (F			26:11					Date of De Month	D:	ay Year	3. Time of Death	
2	/Medic	al	Ruth 4a. Facility Name (If no.	Spene		Mill	er	4b. City, Town, o	r Location of		)ecemb		13, 2009 c. County of Deat		
	Examin	EI	Hillhaven			,		Adelphi				- 1	rince Ge		
l	Funeral Director		5. Social Security Numb 218-20-087	¹ 3	х ]м 24Ожт 7.	Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birt (Month, Da ept 6,	y, Year	9. Birt Co 26 Wash	thplace (State or Foreign buntry)	
	and www.		Usual Residence of De 10a. State 10	cedent b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mary a-f sho	tor	MD M	fontgome:	ry	Silv	er Spr	ing						1 □Yes 2 □ No	
	ith the	Funeral Director	10e. Street and Number					10f. Zip Code					0g. Citizen of What Country?		
	eath w is 23a must b	eral	216 Lexing	gton Dri	7e 12. Was Decede	ant Ever in II	S 13 1	20901	tienanic Origin	n? (Specify	/ Ves or No		ited Sta		
2000	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □		Armed Force 1 Tes 2 If Yes, Give Year or Date	es? [☑No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Black, Whit	e, etc.	
ה ה	72 hc "natui	eted	15 (Specify o	Decedent's Edu	cation e completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most o	of working		16b. l	Kind of Business/	/Industry	
7	within ene. than he Me	Completed	Elementary/Seconda	ary (0-12)	College (1-4	or 5+)		oo nor use retire emaker	d)			0	wn Home		
2	al Hygi other vent, t	Be C	17. Father's Name (Firs	st, Middle, Last)									n Sumame)		
y I	Menta Menta arked atic ev	2	Louis B. S						Minn	ie B.	Hano	1d			
ğ	d 2 shoth and the and 7 is m		19a. Informant's Name			1 \		ng Address (Street							
ָה ה	f Heall tem 2 other		Robin M. N 20a. Method of Disposit	tion		hter)		Lexingto sition (Name of matory or other pla		Date			Location - City or		
	Pages nent o ant: If Iry or		1 X Burial 2 □ C 4 □ Donation 5 □			ate		Cemetery		12/19	/2009	Ro	ckville,	, Maryland	
מון	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other once.		21. Signature of Fune	al Service Licens		M00982	93	2. Name and Address	ess of Facility	Rapp 1ver	Funer	al	& Cremat	ion Service 1 20910	
ı			23a. Part1. Enter the c shock, or heart fa	disease, or comp ailure. List only o	ications that cau ne cause on eac	sed the death	n. Do not ent	er the mode of dyi	ng, such as ca	ardiac or re	espiratory a	rrest,		Approximate Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	al	a			Thrive						Onset and Death	
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١,	D ≠	ner	Sequentially list conditi if any, leading to imme cause. Enter Underlyir Cause (Disease or inju	ions, ediate	Due to (or	as a consequ	uence of):								
	ecuter and -trans	Examiner	Cause (Disease or inju that initiated events resulting in death) Last	_	C	as a consequ	ience of):								
0/00,	tificate be executed g physician and as the burial-transit	阿田		·	- Dac to (or	as a conseq.	acrioc or).								
000	tificate ng phy: as the	ledical													
.O. DO.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 ☐ Yes 2 ☒No 9 ☐ Unknown	egnant inths?		h 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у				23d. Date of de Month	livery Day Year	
'n	ss that gned b	by Pr	Part II. Other significal	nt conditions co	ntributing to deat	th but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco	use contribute to	o the cause of death?	
20.00	require									_	1 🗆 '	Yes 2	2 <b>X</b> No 3 □ P	robably 4 Unknown	
ם ום	To the Hospital or Attending Physiclan: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed											prior to death?	utopsy findings available completion of cause of s 2 □ No	
<u> </u>	siclan certifi irector	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☒ No		Hospital:	ationt 2	ER/Outpatier	nt 3 DOA Oth	26. Place o				6 □Other (Spe	-16.1	
5	g Phy ter this neral d	-	27. Manner of Death		28a. Date of		28b. Time of Injury						ury occurred	ecity)	
	tendin eath. tor: Af the fur	catio	2 Accident	Fending investigation Could not be				M 1 □	Yes 2 □ No	0					
	tal or Atres after deal Direct	Certification:	4 ☐ Homicide	determined	building	, etc. (Specify	()	eet, factory, office			City or To	wn, Sta	ite)	ural Route Number,	
	he Hospi n 24 hour he Funer pletely fill	Medical	29a. Certifier 12 (Check only 2 one)	Certifying Phy Medical Exam	siclan: To the be iner: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and opinion, death	place, and h occurred	due to the at the time,	cause( date a	(s) and manner a and place, and du	s stated. e to the cause(s)	
	With to t	Σ	29b. Signature and title	e of certifier		)		29c. Licens					ate signed (Mon		
i			On Name and add	1/00	2CX	of do the (1)	1		1897			De	ec. 14, 2	2009	
			30. Name and address Njide Udoo					Print) Dr., #100	, Elic	ott (	City,	MD	21042		
l _{at}	Sta Registr		31. Date filed (Month. I			jistrar's Signa									
			-# G				9//								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:37 CM 200 rard 2 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner mor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. Days 1 **€ X**M 2 □ F 55 Maryland Director 215-68-0604 01/31/1954 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Harford Edgewood Maryland 1 □Yes 2XXXII Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 Lasonia Court 21040 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No of Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X TNo Specify: þ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Software Engineer Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Benjamin Mitchell Bertha Dorothea Lackner P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Mitchell (Son) 3051 Benefit Court, Abingdon, Maryland 21009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Bayview Crematory, Inc 12/17/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}nski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Fastern Avenue, Essex, Maryland 21221 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final disease or condition resulting in death) oul monor. Physician ideo parthic months /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 110 1 □ Yes 1 ☐ Yes this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c, License number D66539

Division of Vital Records, Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

certificate

Physician: The law requires that the death certificate be executed

Box 68760.

P.0.

State Registrar

act 31. Date filed (Month, Day, Year)

alc

30. Name and address of person who completed cause of death

**ts** Universit 32 Registrar's Signature

Item 23a) (Type, Print)

land Hedical Contar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Lee Melka December 11:14 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Ivv Hall Geriatric Center</u> Middle River Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Months Days Hours 6/10/1960 Director Maryland 213-82-6925 49 Usual Residence of Decedent or 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Franklin Avenue Apt 1105 21221 S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Apartment Complex permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leach Bette Newlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 Apt 1105 Bette Harmon (Mother) 1000 Franklin Avenue Maryland Essex, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/16 2009 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of the on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Progressive

Due to (or as a consequence of): Physician/ Medical Examiner Herants Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months?
1 Yes 2 No ☐ Pregnant at time of death☐ Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: ' 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X** No Hospital: Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 XNatural 5 Pending 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D 314 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

N

32. Registrar's Signature

HASHMIMD 82

31. Date filed (Month, Day, Year)

DEC 1 & 2009

EUTAW ST

BALTIMORE MD 2/201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Miku taicis lelvin December 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death
Baltimore County of Death **Examiner** Johns Hopkins Bayview Care Amore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 18,1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maryland 213-28-9107 **Director** Usual Residence of Decedent f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shorthe Wolcal Experience as be retified at Director 1 □Yes 2 No MD Baltimore **Dundalk** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 8265 Del Haven Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the "Wolfgal Examina" is used. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Haas Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Tailor Tailoring 17. Father's Name (First, Middle, Last) unkn. 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Mikutaicis Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8265 Del Haven Road Dundalk, Maryland Phyllis A. Mikutaicis (Wife) 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 12/16/2009 Dundalk, MD 21. Signature of Funeral Pervice Lice ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arrhythmia **Physician** minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Palmonary Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Exami and Records, P.O. Box 68760 physician Physician/Medical the attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ficate has been signs. 7, page 2 should b 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes certificate Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? After 1 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation n 24 hours after death.

Re Funeral Director: Af olderly filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

8+1

State Registrar 31. Date filed (Month, Day, Year) 18 2009

W. B. Greenought mo 32. Registrar's Signatur

30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

5505

Baltimore

December 14, 2009

Bay Dien Circle

273

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-30-09 State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month Day 12 200 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Square Hospital Rosedale Baltimore FRANKLIN If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months 1 □ M 2**X**□ F 6,1921 88 213-18-0364 Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examilian an ust be notified at Director 1 ☐ Yes 2 TxNo MD Baltimore Dunda1k 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21222 United States 218 Colgate Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Specify: 2 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Mortgage Officer Banking Industry permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Tauber Barbara Batz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Birch Brook Lane Abingdon, Maryland 21009 Virginia B. Cotter (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 12/19/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** varid Ventricula disease or condition resulting in death) /Medical Due to (or as a consequence of): espense Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-trar Due to (or as consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Drova 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2∭X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

5

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUARE

9000 FRANKLIN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23aPtI,25,27,28a-f per me, 898,12718/09dhb

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 2 Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Year 1152 AM VU 2000 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memcal OF Marin D If Under 8. Date of Birth (Month, Day, Year) April 20,1955 Maryland 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2□F 54 Months Days Hours Min Director 220-64-0586 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar is ust by a chilled at 1 TYes 2 □ No Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 856 St. Lemmon 21223 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No <u>م</u> Specify. Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harry McFadden Mary Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and ∟ ont of Health and ... nr 27 is Deborah Ε. Ducker/ Sister 110 Glendale Ave. Glen Burnie, MD. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic CrematoryLLC.Nov.24,2009|Glen Burnie,MD. 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signure Funeral Service Licensee allen 328 Sulphur Spring RD. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anoxic Brain Injury Immediate Cause (Final disease or condition Physician disease or condition resulting in death) /Medical Due to (or as a consequence 4) Narcotic Intoxication Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION A Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 □No 1 □Yes 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 🗆 No 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury
Found, Day, Year)
1706/2009 27. Manner of Death Found: 28c. Injury at Work? 28d. Describe how injury occurred Certification: + Natural
2 ☐ Accident 5 Pending Unknown 1 □Yes 2 X No investigation 12:09 p^M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Boute Number, City or Town, State) Found: 856 Lemmon 4 Homicide Found: Home Street, Baltimore, MD decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2.

State Registrar 29b. Signature and title of certifier

atherine 31. Date filed (Month, Day, Year)

OFC 18 KUUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith

M.D

S.

22

32. Registrar's Signature

29c. License number

18179

29d. Date signed (Month, Day, Year)

Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. Decedent's Name (First, Middle, Last)   2. Date of Death Month   Day   Year   3. Time of Death   Day   Year   Day   Nov Death   Day   Nov Death   Day   Day   Death   Day   Day   Death   Day   Day   Death   Day   Day   Death   Day   Death   Day   Day   Death   Day   Day   Death   Day   Day   Death   Day   Death   Death   Day   Death   Death   Death   Day   Death   Death   Death   Death   Death   Death   Death   Death   Death   Day   Death		ŀ	For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of F			iene 009	40476
And rew T. Minor Examiner  Fund 1900 Montford Drive  Fund 1900 Montfor						<del>-</del>				3. Time of Death
## Printed Done    Printed Done			Andrew T. Mihok							8:10 PM M
Second protection   Control   Cont			4a. Facility Name (If not institution, give	street and number	7)	4b. City, Town, or	Location of Dea	ith	4c. County of Death	
212-30-4767   If M = F   75    Yes   Morthol   Days   Not.   Morth Days   394   Pennsylvania	and the second									
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Due to (or as a consequence of):    Secure training in death)   Secure training in the underlying cause given in Part I.   Secure training in death   Secure training in death)   Secure training in death)   Secure training in death)   Secure training in death   Secure training in death)   Secure training in death)   Secure training in death)   Secure training in death   Secure tr	Physician		Immediate (Final	ne cause on each	metack	whic D	net to	CHORO	1	Onset and Death
Sequentially list conditions, in any leading to investigating and accesses that Maching in death) Last    Sequentially list conditions in any leading to investigating a large leading to investigating a large leading to investigating a large leading to investigating a large leading to investigating a large leading to large leading to investigating a large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leading to large leadin			resulting in death)	Due to (or a			107.000	ocy ( c		2 grs.
State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	<b>Examiner</b>	_	Commentation that are stated							
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FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   1   Year   2   No   3   Probably   4   Unknown   1   Year   2   No   3   Probably   4   Unknown   24a. Was an autopsy performed   25c. Marcase referred to medical evaratiner?   1   Year   2   No   3   Probably   4   Unknown   24a. Was an autopsy performed   25c. Marcase referred to medical evaratiner?   1   Year   2   No   3   Probably   4   Unknown   25c. Marcase referred to medical evaratiner?   1   Year   2   No   25c. Marcase referred to medical evaratiner?   1   Notatural to the obstitution of the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the past 12   Notatural to the	be ex be ex ician ourial			Due to (or a	s a consequence or):					
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29b. Signature and title of certifier  29c. License number  29d. Date signed ( <i>Month, Day, Year</i> )  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ashkan Bahrani  9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State  31. Date filed ( <i>Month, Day, Year</i> )  32. Registrar's Signature	death	icia	in the past 12 months?	4 Pregnant	at time of death 5		у			
290. Signature and title of certifier  290. Date signed ( <i>Month, Day, Year</i> )	by the	hys		9 🗆 Unknown						
29b. Signature and title of certifier  29c. License number  29d. Date signed ( <i>Month, Day, Year</i> )  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ashkan Bahrani  9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State  31. Date filed ( <i>Month, Day, Year</i> )  32. Registrar's Signature	s tha		Part II. Other significant conditions con	tributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
29b. Signature and title of certifier  29c. License number  29d. Date signed ( <i>Month, Day, Year</i> )  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ashkan Bahrani  9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State  31. Date filed ( <i>Month, Day, Year</i> )  32. Registrar's Signature	aquire en sig	ed						1 □ Ye	es Pro	bably 4 🗌 Unknown
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29b. Signature and title of certifier  29c. License number  29d. Date signed ( <i>Month, Day, Year</i> )  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ashkan Bahrani  9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State  31. Date filed ( <i>Month, Day, Year</i> )  32. Registrar's Signature	ttend death death stor: / the	icat	3 ☐ Suicide 6 ☐ Could not be	28e Place of Ir	niury - At home farm st		Yes ∠ □ 140	28f Location (St	reat and Number or Bu	ral Boute Number
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ashkan Bahrani 9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	omple omple	Me		2-7		29c. Licens	e number	2	9d. Date şigned (Month	, Day, Year)
Ashkan Bahrani 9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	FSFO		<b>•</b>	/_		D5	4841		12/10/09	
Ashkan Bahrani 9114 Philadelphia RD Ste208 Baltimore ,MD 21237  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type,	Print)	,		, , ,	
State 31. Date filed (Month, Day, Year) 22. Registrar's Signature		1	Ashkan Bahtani	9114	Philadelphi	La RD St	e208 Ba	ltimore,	MD 21237	
				32. Regis	trar's Signature	20 R				

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200^{year} 9:25 AMM December /Medical <u>Brian H. Mason</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase <u>5500 Friendship</u> Blvd #1109 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 124-28-9628 1917 Maryland Director Apr 18, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Express must be notified at once. 1 ☐Yes 2√ No Director Chevy Chase MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 USA 5500 Friendship Blvd #1109 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) geologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Fairweather George Harold Mason ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5500 Friendship Blvd #1109 Chevy Chase, MD 20815 Frank Turner/stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatur of Euneral Arryi Fonal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate use (Final disease or co uson resulting in death) Prostate **Physician** CHACE 7045 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 100 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 09969127 12,10,200 , M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 700, Chen Chix MD 20815 5530 Wisconsin Brent Cole, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 18 2009 Registrar

			Amend #26,	ase Type or Pr per verbal ( State of N	i <b>nt in E</b> 1898 I laryland	Black Ir 2/18/0 d/Depa	delible 9 TT artment	e Ink - An of H	r. <b>Ens</b> nend lealth	#31 p	Copie er DVR ental Hy	s Ar	e Legible e		
		-	State Registrar		•		tificate					Reg. N	2009	40478	3
	Physicia Medic		1. Decedent's Name (First, Midd Henry Davis							L	2. Date of De Month ecemb	ath D	ay Year	3. Time of Death	M
-	Examir	er	4a. Facility Name (If not institution Johns Hopkin	s Bayview	Med.	Ctr.	4b. City, To	Ва	ltim	nore		$\perp$		/A	
	Funeral Director		5. Social Security Number 184–22–5468	6. Sex 7. Ag	ge (In yrs. Ia. 81	st birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	Date of Bir (Month, Da	ay, Year)	9. Bir 928 Sou	thplace (State or Foreig buntry) th Caroli	[™] in
	land show dat	1 1	Usual Residence of Decedent  10a. State 10b. Count	•	10c. City	, Town or Loc								10d. Inside City Limits	
	he Mary or 28a-1 s notifie	Direc	MD 10e. Street and Number	N/A			B. 10f. Zip (		imor	- <u> </u>	. 1	10g. C	Citizen of What Co	1 X Yes 2 □ N	10
	s 23a nust be	eral	5017 Truesda	le Avenue					212	206		5	USA		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Von Give		l1	Vas Decede Yes, specif	y Cubar	n, Mexicar	n, Puerto Rio	y Yes or No- can, etc.)		14. Race - Ame Black, Whit Specify: B1	e, etc.	
15-0	72 hour n "natu ledical	uplet	15. Deced (Specify only high	ent's Education nest grade completed)		16a. Deced	ent's Usual and of work NOT use r	done d	ation <i>uring mo</i> s	at of working		16b.	Kind of Business	Industry	
212	within giene. er thar	Be Completed	Elementary/Seconday (0-12) 10th Grade	College (1-4 or	5+)	Mecha		,	quip	oment	Op.		Railro	ad	
	be filed ental Hy rked oth ic event	To Be	17. Father's Name <i>(First, Middle,</i> Ezekiel Nels						_	er's Name (F Sanna	First, Middle,	, Maidei	n Surname)		
, Maryland	d 2 should salth and M n 27 is mar er traumat		19a. Informant's Name/Relation Teresa McGra		er	19b. Mailin 521	g Address (	Street a	on A	er or Rural Fi Avenu	Route Numbe e Bal	er, City o	or Town, State, Zi	p Code) ID 21205	
Baltimore,	Page 1 an nent of He ant: If iten ary or oth		20a. Method of Disposition 1 ፟፟ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		CE	ace of Dispo emetery, cren Zion	natory or oth	her placi	e) ry 1	Dat 2/17			Location - City or nsdowne		
Balt	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name and Address of Facility Chatman-Harris Fundable 22. Name											ne			
4	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complications that cause conly one cause on each lir a	llu	1 av	r the mode		2	0.1	espiratory ar	rrest,		Approximate Interval Between Onset and Death	
30	te be executed sysician and re burial-transit	dical Examiner	Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as d.										,	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 D Fetal at time of d	Ideath 3	Ectopic pr Other (spe		у				23d. Date of de Month	elivery Day Year	
P.O.	ss that th igned by be detac	by Pr	Part II. Other significant condit	tions contributing to death	but not resu	ulting in the u	nderlying ca	ause giv	en in Part	l.				o the cause of death?	
cords	2 38 3	npleted	PossiMe	Parkinson	is l	isle	É				24a. Was	an	24b. Were au	utopsy findings available completion of cause of	e
I Re	rs <b>ician</b> : The law r s certificate has <b>t</b> lirector, page 2 sl		25. Was case referred to medica					ac Di	as of Dee	ath (Check o	1 L Yes	ormed? 2 <b>X</b>	death? No 1 ☐ Ye	s 2 🗆 No	_
Vita	Physicial this certi al directo	To Be	examiner? 1  Yes 2 No	Hospital:	tient 2 🗆 I	ER/Outpatier	t 3 00	Othe	er:	ursing Home		<del>idenc</del> e	6 Other (Spec	cify)	
Jou	ling Ph	ate:	27. Manner of Death  1 Natural 5 □ Pend			28b. Time of injury	- 1	c. Injury work	? _		d. Describe l	how inju	ury occurred		
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page	Certificate:	3 Suicide 6 Coul	mined 28e. Place of In	jury - At hor tc. (Specify)		M eet, factory,		Yes 2	_	f. Location ( City or Tov			ıral Route Number,	
	ne Hospita in 24 hours ne Funeral pleted fille	Medical	(Check 2 Medical	ng Physician: To the best of Examiner: On the basis of ng Nurse Practioner: To the	examination	and/or invest	igation, in m	y opinio	n, death o	ccurred at th	e time, date a	and plac	ce, and due to the	cause(s) and manner sta	ated.
	To the within com	-	29b. Signature and title of certifi	er Lu	3		29c.	License	number	420	u	29d. D	ate signed (Mont	h, Day, Year)	
			30. Name and address of person	mult MD	494	1 Eas	rint)		70	Ew	Know	10	MD	2122V	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signati	8 2009	h		A	ha	Mal				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland / Der Maryland / Der Megistrar	artment of Health and 18898, 12/18/09dhb erifficate of Death	Mental Hygiene Reg. No. 2009 40479
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year  3. Time of Death
/Med	ical	Helen I.	Overton	December 3, 2009 1:10PM
Exami	ner	4a. Facility Name (If not institution, give street and number)  Future Care Chesapeake	4b. City, Town, or Location of Death	Anne Arundel
Funeral Director		5. Social Security Number  102-05-6366  6. Sex 1	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	
land wc		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
Mary I-f she	ō	MD Anne Arundel Gl	en Burnie	1 ⊟Yes 2v⊟No
th the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ath wi	la L	319 Wellham Ave	21061	U.S.A.
and LILIS-UU36  be filed within 72 hours after death with the Maryland ntal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Expanient must be recitied at	by Funeral	1 Never Married 2 Married 1 Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ☑ No Specify:	io Rican, etc.) Black, White, etc.
Z I Z I 3-UU36 d within 72 hours aff giene. rr than "natural", or	Completed to	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
Ithin 7	l ple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	
J C I		12th grade   na A	dministration	Social Security Ad
	To Be	Fitzthomas Sealy		ne (First, Middle, Maiden Surname)  cent Sealy
paritiniofe, interpriate permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone.			ing Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip Code)
T and 1 and Health		Bernard Overton-Son 319  20a. Method of Disposition 20b. Place of Disp	· · · · · · · · · · · · · · · · · · ·	Glen Burnie, Md 21061  Date   20c. Location - City or Town, State
diffillore, rmit. Pages 1 ar partment of Hee portant: If item y Injury or othe ce.		X□Burial 2□Cremation 3□Removal from State 4□Donation 5□Other (Specify)  Cedar	ematory or other place)	LO/09 Baltimore, MD
rmit. F spartm sportan y Injui		21. Signature of Funeral Service Licensee	2. Name and Address of Facility	Bazezmoze, III
<b>0</b> 20 <b>5</b> 5 <b>8</b>		Franco Okes Haham M	arch F/H West 300 Wabash Ave	Baltimore, Md 21215
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Hemates	c or respiratory arrest, Approximate Interval Between Onset and Death
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the death certify the attending	Physician/Medical		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
law requires that the dias been signed by the 2 should be detached	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
requir een si nould l		Renal Faiture afrial fabrillation		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
The larate has	Completed	atrial fabrillation		24a. Was an autopsy performed?  1 □ Yes 2 No   24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Physician: T this certificat ral director, pe	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	O4h	th (Check only one)
Physer this eral di	15	1 X Yes 25 Ho Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manper of Death 28a. Date of Injury 28b. Time of Death	nt 3 DOA 4 DAUTSING H	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
nding ath. r: Afte e fune	atior	1	Work?	Multiple falls
To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After to completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)  Unknown		28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown
e Hospit n 24 hours e Funera letely fille	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place ovestigation, in my opinion, death occu	and due to the cause(s) and manner as stated
Vithin Complete	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		many ms	D57531	December 3, 2009
		30. Name and address of person who completed cause of death (Item 23a) (Type,		
- C4-	to	31. Date filed (Month, Day Year) 32 Renistrar's Sinnature	y, rule 204,	mucosalle, mo 21,08
Sta Registr	ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Mohrt Ness 8601 Veterals Mohrt 1998) 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 18 2009 August 1998.	la d	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean Dunn Peake December 2009 6:29 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shadetree Lane Prince George's Laurel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign · 1<u>926</u> Days OCt. 29 1 □ M 2 X F Months Hours Min Virginia Director Yrs. 229-28-9284 83 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2XXNo MD Prince George's Laurel ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12234 Shadetree Lane 20708 items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" Specify: White 3X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o မ Frank Dunn Annie Delvaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6117 Parkway Drive, Laurel, Nancy Jean Peake/Daughter MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Clarksville, MD Columbia Memorial Pk 12/18/2009 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licens M01103 313 Talbott Avenue, Laurel, MD 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immedial Cause (Final Onset and Death Physician/ disease or condition Myocardial Infarction Acute Medical resulting in death) Due to (or as a consequence of) Examiner Arteriosclerotic Heart Disease 5 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsy performed? Yes 2 \sum No death? certificate 1 Yes 2 X No Division of Vital the Hospital or Attending Physician: after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Peter B.

31. Date

J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3921

32. Registrar's signature

Sherer,

D21910

Ferrara Drive, Wheaton, MD 20906

December 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department Piles Hoand Mental Hygiene For State Registrar 40481 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11-21-2009 Helen Margaret Patacca 805 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3001 St. Clair Drive #404 Abingdon Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Months Days Min. 1 □ M 2 💢 F 81 216-20-3607 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Malical Examiner must be restricted an once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 ☐ Yes 2 No Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 St. Clair Drive #404 Funeral 21009 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: ģ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmotologist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James S. Janowick Maude Barnes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfonso Patacca (Spouse) 3001 St. Clair Dr #404 Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gar. 11-25-2009 Baltimore, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failure disease or condition resulting in death) Kenal Vears /Medical Due to (or as a consequence of) Examiner Vichetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be execute burial-t Due to (or as a consequence of) P.O. Box 68760 ned by the attending physician detached for use as the buria as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been Chronic subdured nemaserin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 760 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending Injury **Unknown**^M Probable multiple falls Unknown 1 ☐ Yes 2 🛣 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

State Registrar Kenwood

arke

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

32.

5701

Registrar's Signature

Kloesz

we not 31. Date filed (Month, Day, Year) 29c. License number

D 31295

13 out

29d. Date signed (Month, Day, Year)

21206

11/24/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of F <i>tificate of L</i>					3 40482		
	Dhysisia	- /	Decedent's Name (First, Middle	e, Last)					2. Date of De			3. Time of Death		
	Physicia Medio				Carol	e Pat	tison-Bro	wn	Decemb	er ]	2, 2009	7:10 A ^M		
	Examin	er	4a. Facility Name (if not institution		7		4b. City, Town, or	Location of Death	1		c. County of Deat			
	Funeral		Patuxent Healt  5. Social Security Number		. 11tat e (In yrs. Ias		Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		Prince G	eorge thplace (State or Foreign		
	Director		213-40-6212 Usual Residence of Decedent	1 □ M 2 🖾 F	69	Months Days Hours Min. (Month Day					40 Mar	yland		
	and show dat	ī	10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits		
	Mary 28a-f otifie	<b>Funeral Director</b>	MD Princ	e George	Laur	el						1 🏹 Yes 2 □ No		
	h the	al D	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?		
	th with ms 23 must	ner	14800 4th Stre				20707				S.A.			
	r deal or iter iner		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White			
036	s afte ral", c Exam	ed by	3   Widowed 4 □ Divorced	If Von Civo	No	1	☐ Yes 2 🛛 No	Specify:			Specify: Whi	te		
2	hour hatur dical	olete	15. Decede	nt's Education est grade completed)	1	16a. Deced	ent's Usual Occupa	ation		16b. F	Kind of Business			
21215-0036	hin 72 ne. than ' e Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO	ind of work done d NOT use retired)	unng most of wor	king					
η Ω	Hygie Hygie other int, th	Be	17. Father's Name (First, Middle,	1		Hair	Stylist			Hair Salon				
Maryland	be filk ental I ked o c eve	To	Carroll Robert	· .				18. Mother's Nan	ne (First, Middle, Evelyn '		,			
ary	nould Ind Mi s mar umati		19a. Informant's Name/Relations		- 7	19b. Mailin	g Address (Street a			_		Code)		
Σ̈́	d 2 sk atth a 27 is er trai		Laura Gobbel	/daug	hter						-	vania 15237		
ore	of He of He of item of oth		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation	2 Domeyel from State			sition (Name of latory or other place	9)	Date	20c. L	ocation - City or	Town, State		
<u><u>Ĕ</u></u>	Page ment tant; l		4 Donation 5 Other (				el Cremat	· .	9/09	Ođe	nton, Ma	aryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	)//	00773	22 I	Name and Addres	s of Facility Funeral	Home, I	P.A.	errland 20	0707 4300		
Т			207  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heavitailure. List only one cause on each line.											
-4	Pnysician/		Immediate Cause (Final disease or condition	Coronar		ery D	isease					Interval Between Onset and Death		
	Medical Examiner	resulting in death)  a.  Due to (or as a consequence of):												
		Jer	Sequentially list conditions,	b. Due to (or as a	a cunceque	Hibe of,:								
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events											
	exectian an irial-tr	ĕ	resulting in death) Last	Due to (or as a	a conseque	ence of):	·	-						
760	death certificate be executed ne attending physician and ed for use as the burial-transit	edical		d				<del>-</del>						
687	ertific ding p		IF FEMALE:	23c. If yes, outcome	of pregnan	CV								
ŏ	eath o	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	/		1	23d. Date of deli Month	ivery Day Year		
P.O. Box	requires that the de been signed by the should be detached	hys	9 Unknown	9 Unknown										
	anec gnec	ا ۾	Part II. Other significant condition					en in Part I.	23e. Did to	bacco u	use contribute to	the cause of death?		
đs,	equires	ted	Diabetes Melli	tus, Congest	ive F	leart :	Failure		1 🗆 `	Yes 2	□ No 3 □ Pr	obably 4 XXInknown		
SCO	law requires that the has been signed by the e 2 should be detach	Completed	Hypertension						24a. Was a	SV	prior to c	opsy findings available completion of cause of		
Ž	sician: The law sicertificate has birector, page 2 s		25. Was case referred to medical			_			perfo	2XX	death?	2 XXIo		
/Ita	sicial s certi lirecto	To Be	examiner?	Hospital:	0 [] E	R/Outpatient	Otho	ce of Death (Chec						
<del> </del>	Attending Physician: T r death. sctor: After this certifical by the funeral director, p		27. Manner of Death	28a. Date of injur	ry 2	8b. Time of	28c. Injury	at	ome 5 L Resid		Other (Speci	<u>fy)</u>		
O	eath.	lical	1 XX Natural 5 Pendir 2 Accident Investi	gation	, rear)	Injury	M 1 □ Y	yes 2□No			•			
Division of Vital Records,	l or Atta after de Directo	Certificate:	3 Suicide 6 Could 4 Homicide determ			ne, farm, stre	et, factory, office		28f. Location (S City or Tow			al Route Number,		
<u>.</u>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 $\square$ Medical E	Physician: To the best of examiner: On the basis of ex	xamination a	and/or investi	gation, in my opinior	n, death occurred a	nt the time date a	nd place	and due to the c	aucale) and manner etated		
	o the vithin or the comple	ž	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the l	best of my k	knowledge, de	eath occurred at the 29c. License	time, date and place	ce, and due to the	e cause(s	s) and manner as stee signed (Month)	stated.		
	- > - 0		> H15	nopaj m	D			3181				15, 2009		
	101	Ì	30. Name and address of person	who completed cause of de	eath (Item 2	3a) (Type, Pr				של	CHIDEL	13, 2009		
	1		Rajkumar G. E		704	Groma	an Avenue	, #T-1 I	aurel,	Mary	land 20	707		
H	Stat Registra	e r	31. Date filed (Month, Day, Year)	32. Registra	r's Sio atu	- Alan								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2009 7:06 A M Barbara Mary Plummer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1815 Watch House Circle S. Anne Arundel Severn Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Year) 06-14-1940 Director Yrs 107-32-4221 69 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 X No MD Anne Arundel Severn ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1815 Watch House Circle 21144 United States items ? within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 M Married ō þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates "natural", Specify Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 House Wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic is any injury or other traumatic of ence. Eleanor Cooley Edwin Lanigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Arthur E. Plummer / Husband</u> Severn, Maryland 21144 1815 Watch House Circle S. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 12-18-2009 Crownsville, Maryland Funeral Gervic Name and Address of Eacility Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner 10 vtenio Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on transit Exam and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year led by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death? autopsy performe page 2 140 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 NA6 Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 잍 Director; After this in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending after death 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral Direct completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 200 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 S. Crain Hoy 106 8 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 NP G898 12/18/09 TT Mental Hygiene 2 0 9 40484 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 2009 04:05 Santo Pistorio рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 🛛 M 2 🗆 F Days Hours Min. Months 06707/1933ar Director 76 218-28-6159 Usual Residence of Decedent 28a-f shov 10a. State 10b County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 Yes 2 X No ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21236 U.S.A. 7848 Saint Thomas Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 1953-61 White Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MD Dept. Of Corrections Transport Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked o ပ္ Salvatore Pistorio Antoinette Gelcomino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7848 Saint Thomas Drive, Baltimore, MD 21236 Santa M. Pistorio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entonoment Dulaney Valley Memorial 12/14/2009 Timonium, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Chronic mylogenous months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month ate has been signed by the a page 2 should be detached it 1 ☐ Yes 2 ₪ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò erebrovasarlar vasurlar accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 24 hours after death. Funeral Director: After this certificate Yes 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar (RNP

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grant

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R149194

Touson,

December 11, 2009

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 🔊 🎧 🤾 40485 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician FRAIVCIS POWDER 2009 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUNDALK BALTIMORE FUTURE CARE NORTH POINT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 217-12-9251 85 Director Aug. 13,1924 Maryland Usual Residence of Decedent r 28a-f ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD <u>Baltimore</u> <u>Dundalk</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 the Medical Exprehier must be 23a 432 Trappe Road 21222 United States filed within 72 hours after death Funeral or iteme 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Amed Folces.

1 Xes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: β Specify: 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Machinist Manufacturing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental and Mental Leo Powder Frances Khuback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Mrs. Hilda C. Powder (Wife) 432 Trappe Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 12/18/2009 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 -50217C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Condis /Medical Examiner Amyos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mich friening 3 Probably 4 Onknown Certification: To Be Completed 1 ☐ Yes 2 ☐ No been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate MYTULETSION 1 Yes 2 No 1 Yes 2 No 25. Was case elerred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this ieral Director: After th filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) M.D. D69540 12 16 2009 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah Jigar 8813 Walthen Goods Rd Suite 204. Parkwille MD 21234 31. Date filed (North, Day Year)
DEC 8 2009 32. Registra 's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, Physician/ Month 2009 December 1:00 A Lucy Μ. Plowden Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 M 2 TF July 19, 1940 Director 215-42-5253 Maryland Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 No Maryland Baltimore Timonium or 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 12251 Roundwood Road <u>Unit 402</u> 21093 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. or i 1:00 4 þ 1 Never Married 2 - Married ☐ Yes 2 X No 21215-0036 1 Yes 2xXNo Specify: If Yes, Give Completed 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Real Estate Realtor Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ဂ္ Agatha M. Corasaniti <u>Guv J. Matricciani</u> Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : 12251 Roundwood Road Mr. James L. Plowden (Spouse) Unit 402 Timonium, Md. 21093 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other to Baltimore, I or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Dther (Specify) Dulaney Valley Mem. Cdns. 12/19/2009 Timonium Maryland 22. Name and Address of Facility 21204 Ruck Towson Funeral HOme, Inc. 1050 York Road Towson, Mil. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death of Hysician heukemia weeks Medical resulting in death) Examiner multiple muclon Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner Due to for da a consequence of Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12149194 December 16, 2009 CRNP Just. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 H. Charles Topuson MO Grant 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CRISTELLO PADRUN Month Dav Year 10:25AM 2009 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Charles Village Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F 460-36-8897 Director June 29, 1935 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits ul Hygiene. . other then "neture!", or llems 23e or 28e-f ehow vent, the Mcdical Examiner must be notified at MD Baltimore 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 N. Chalres Street 21218 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter woodwork 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental is marked Rodelio Padron Francisca Jaso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health ar
important: If item 27 is
eny injury or other trau George Seamon/nephew 1573 Severesien Avenue Bohmia, NY 11716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Sign vure of Euneral Service Licensee, State Anatomy Board 655 W. Baltimore Street in Baltimore, MD 21201 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onary **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 200 No 1 Yes 2 No 1 ☐ Yes Division of Vital :: After this certifica e funeral director, p To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death.
I Director: Aft
d in by the fun 1 Tes 2 No 2 Accident 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 164 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 057543 PHYSICIAN Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDHU, MD 1940 W. BALTIMORE ST. BALTIMOLE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 18 ZUUS

32. Registrar's Signature

kneen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Soon Sang Ro December 16,2009 8:00 A.M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore County Manor Care Ruxton Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 1 F Hours Min. 213-11-4325 87 Seoul Korea Sept.02,1922 Usual Residence of Decedent 10a. State 10b County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 E. 25th Street Apt.4K 21218 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 PNo Specify: Specify: Korean 3 → Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 06 N/A Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gee Ro (Daughter In Law) 56 Rhodes Place Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 1 2009 Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility
Peacuril 1 Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093, P.A. 21. Signature of Funeral Service Licensee 911 23a. Part 1. Int if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or the article for the a Approximate Interval Between Onset and Death Dementica Fnd story disease or condition resulting in death) Due to (or as a consequence of): Accuident erelyo vascular if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? endiles territoria 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

1 ☐ Yes 2 ☐ No

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

WING

NOZWST

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21204

**Physician** /Medical Examiner 68760 Box P.O. Records, Hospital or Attending Physician: The law Division of Vital

Examiner attending physician the as for use the ģ signed l page 2 should has certificate director, After thi funeral o n 24 hours after death.

• Funeral Director: A

pletely filled in by the fu death.

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, It a Medical Exemina

Saltimore, Maryland 21215-0036

death with the Maryland

Physician/Medical

þ Completed Be Medical Certification: To

completely within 2 To the State Registrar

J. HIR PARA 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

6 Could not be determined

32. Registrar's Signature

7505

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

08/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 40489 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Rose Harry December 2009 1:10 АМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
December 27, 1925

8. Birthplace (Statement of Statement of 9. Birthplace (State or Foreign Days Hours 122-20-5613 Director 83 Usual Residence of Decedent 10a, State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 South Leisure World Blvd., 20906 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian rmed Forces? Black, White, etc Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 1944–1946 Year or Dates. White 3 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
5+ Elementary/Seconday (0-12) Research Chemist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Joseph Rose Anna Garity 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Rose / Daughter 5710 Joseph Court, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cemetery 14, 2009 Silver Spring, Maryland Signature of Fune Service Censes Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final

Respiratory Failure Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): Examiner Interstitial Lung Disease Sequentially list over title as if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ttending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year been signed by the should be detached 1 ☐ Yes ∠ L 9 ☐ Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Pneumonia, Endobronchial Mass Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available 24a. Was an cate has page 2 s prior to completion of cause of death? autopsy performed? Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other မှ 1 X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 🕅 Natural 5  $\square$  Pending Accident within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

Registrar

only one

29b. Signature and title of certifier

1500 Forest Glen Road, Silver Spring, Maryland 20910 M.D. Irving Ruban, . Date filed (Month 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0063343

29d. Date signed (Month, Day, Year)

December 8, 2009

Anne	Donahue	Ryan
711116	Donance	ryan

Physici		Registrar	ertificate c	of Death	Reg	No. 20	09 404
al Exami		1. Decedent's Name (First, Middle,Last)			2. Date of Death Month December 1	Day Year	3. Time of Death 0347 hrs
ai Laiii	mei	Anne Donahoe Ryan  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of De		4c. County of Death	
		4309 Leland Street		Chevy Chase		Montgomery	,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth		thplace (State or Foreign
Director		226-76-0680 1 M 2 X F 5.	8 Y		May 23,		nington, D.C.
any			ty, Town or Loca	ation			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	Maryland Montgomery	Chevy	Chase			1 Yes 2 X No
h the Maryland 3a or 28a-f sho totified at once.	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	ntry?
th the 23a or notifie		4309 Leland Street		20815		ited State	
ath wi	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?	If	as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue		14. Race - Amer White, etc.	ican Indian, Black,
fter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No specify:		Specify: Wh	ite
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an "n cal Ex	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	- dunng i	most of working life. DO NOT use	retired)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygieviel. In profession of Health and Mental Hygieviel finiportant; If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Comple	5+	Arch	itect		Commercia	Design
al Hyg	Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	· ·	
Ment Mark mark c ever	To B	John E. Ryan  19a. Informant's Name/Relationship (Type, Print )	19b. Mailii	ng Address (Street and Number	ricia E. M or Rural Route Numb		e, Zip Code)
2 sho th and 27 is umati		Steve McConnell / Husband		Leland Street,			
F Heal F Heal Fitem			o. Place of Dispo	osition (Name of cemetery,	Date	20c. Location - City or	
Pages nent of ant: I		4 Donation 5 Other Specify:	crematory or c ate of l emetery	Heaven De	cember 18, 2009	Silvar Spr	ing Maryland
epartn nport		21. Signature of Funeral Service Licensee	22. Re	Name and Address of Facility Dert A. Pumphrey Fu	meral Home/F	Sethorda-Char	The The
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ysician Nedical		23d. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.		, •	ic or respiratory arres	r, snock, or neart	Approximate Interval Between Onset and
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	iner	if any, leading to immediate Due to (or as a consequence	of):				
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une taw requires that the death certificate be executed reate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	by Physician/Medical	d.  UNPENDED  AMENDED  FFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  d.  AMENDED  23c. If yes, outcome of prediction in the past 12 months?  1 Unknown	2 F death 5 C	Other (Specify)	23e. Did tob: 1 Yes 24a. Was ar	Month  acco use contribute to 2 No 3 Pro  24b. Were au prior to death?	the cause of death?  bably 4 V Unknown  utopsy findings available completion of cause of
ician: Ine law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial - transit	Be Completed by Physician/Medical	d.  UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not examiner?	death 5 C	Other (Specify)  underlying cause given in Part I.  26.Place of Death (Che	23e. Did tob: 1 Yes 24a. Was ar autopsy perform 1 Yes 2	Month  acco use contribute to 2 No 3 Pro 24b. Were au prior to death? 1 Y	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of es 2 No
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ REDYK 2257 PM STEVEN 2009 10 ecember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIE MEDICAL CENTER N/A BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min (Month, Day, Year) Sept. 1, Country) Maryland Director 220-01-2255 87 Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 1 No Dunda1k MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Madical Examiner must be. Funeral United States 21222 3124 Shortway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Year or Dates. WWII 3 ☑ Widowed 4 ☐ Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electric Company Set-Up Representative 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Fedryszyk Antoni Redyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3124 Shortway Dundalk, Maryland 21222 3124 Shortway Dundalk, Maryland Mr. Robert Redyk 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 12/14/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23ar Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, MYOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter order ying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 l 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed page certificate Yes 2 M No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending death. after death Director: A d in by the f Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined

within 24 hours a

To the Funeral D

completed filled i

State Registrar

Medical

29a. Certifier

(Check only one)

3 [ 29b. Signature and title of certif

Hardin

31. Date filed (Month, Day, Year)

mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pantie

MO

1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

ELASTERN

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D-0061115

AVENUE BALTIMORE

29d. Date signed (Month. Dav. Year)

12009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13,2009 Radvilas Eleonora Terese 10:05 AM December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Physician/ Medical Examiner permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		9114 H	inton A	venue			Edg€	emere			Balt	imore Co.
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Loreta Bra			r)	19b. Mailir 9114	g Address (Street Hinton	and Number or Re Ave. Ed	ural Route Numbe Igemere,	r, City or Mary	Town, State, yland	Zip Code) 21219
item othe		20a. Method of Disp				lace of Dispo	sition (Name of natory or other place	201	Date	20c. Lc	ocation - City	or Town, State
nent o		1 🗌 Burial 2		3 ☐ Removal from pecify)	State	Lixop,	Service (	Corp 12,	/15/2009	Tot	wson,	Maryland
Departn Importa any inju once,		21. Signature of Jur	neral Service Li	censee /-	Zin/		Narankadı 1922 Wise					
		23a. Part 1. Enter th	he disease, or	complications that	caused the deat	Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	tand 2	Approximate
ysician/		Immediate Cause (I	Final	nly one cause on ea	ach line.	0-6	vob'c	6	laura a	. /	12.	Interval Between Onset and Death
Medical		disease or condition resulting in death)	n	a. Due to	(or as a consequ	ience of):	ORC	CAV 1	20043	aja	2 10	acces
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nsit	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	mediate Iying iinjury	Due to	(or as a consequ	ience of):						
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ding page as	Ĭ	IF FEMALE:		23c. If yes, out	tcome of pregna	ncv					004 D-4- of	delitien
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 🔲 Live	Birth 2  Feta nant at time of c	ıl death 3 □	Ectopic pregnand Other (specify) _	су		Í	23d. Date of o Month	Day Year
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s cert	To Be	examiner?	No	Hospital:	Inpatient 2	FB/Outpatier	_ Oth	er:	Home 5 Resid	dence 6	Other (Sn	necify)
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ath.	ertificate	1 Natural 2 Accident	5 Pending	ation	in, Day, real)	injury		Yes 2 No				
after de Directo d in by ti	ပေျ	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could r determi	ned 28e. Place	of Injury - At ho ng, etc. (Specify		et, factory, office		28f. Location (S City or Tox			Rural Route Number,
hours ineral d fille	Medical			Physician: To the b								
in 24 he Fu plete	Med			caminer: On the bas Nurse Practioner:								ne cause(s) and manner stated. as stated.
withi		29b. Signature and t	title of certifier		m		29c. Licens	e number		29d, Date	e signed Mo	nth, Day, Year)
		1	Del	ADD).	11		DI	5878	1 A	20.	nhe	15, 2009
		30. Name and addre	ess of person w	no completed caus	se of death (Item	23a) (Type, P	rint)	-1 -	\			,

State

Registrar

DEC 1 8 2009

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Please amend
Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 15^{Day} 2009 Year 4:17 AM M Clara E. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Overlea Health & Rehabilitation Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X 91 Months Days Hours JUTY 2 24, 1918 Marvland 216-66-<del>9081</del> **8586** Director Usual Residence of Decedent 10b. County 28a-f show 10c. City Town or Location Baltimore 10a. State Maryland 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1XX Yes 2 ☐ No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Completed by Funeral 2819 Beechland Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Force 9 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give "natural", 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Own Home Homemaker Be ( 18. Mother's Name (First, Middle, Maiden Surname)

Maria Mignini 17. Father's Name (First, Middle, Last) ပ Joseph Donatelli permit. Page 1 and 2 should Department of Health and Important; If item 27 is many injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2819 Beechland Avenue Baltimore Maryland 21214 Margaret Ray/ Daughter-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardens of Faith 1 💢 Burial 2 🗌 Cremation 3 🗋 Removal from State 12/18/09 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Lame and Address of Facility Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each ling Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 wonths? Day Pregnant at time of death 9 Unknown is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work?
1 Yes 2 🗌 No Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 31. Date filed (Month, Day

State Registrar

Division of Vital Records, P.O. Box 68760

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			Please Type or Print State of Mary				-	•	)_
		•	1 State Registrar		tificate of D			2009	3 40494
	Physicia Medic		1. Decedent's Name (First, Middle, Last) FELIKS	ROY	TMAN		Date of Death Month Cember	Day Year	3. Time of Death 3. 18 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) Sinai Hospival of Baltimore	,	4b. City, Town, or L	ocation of Death		4c. County of Dea	N/A
N.	Funeral Director			yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days		Date of Birth	9. Bi	ountry) UKRAINE
	land show d at	tor	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Loc	cation		_		10d. Inside City Limits
	ould be filed within 72 hours after death with the Maryland did Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show marked other than "matic event, the Medical Examiner must be notified at	Director	MD BALTIMORE	BALTIMOR	10f. Zip Code		100	g. Citizen of What C	1  Yes 2 X No
)	s 23a o	Funeral	6950 BROOKMILL ROAD, #1D			1215			USA
<b>.</b>	er death or item niner n	by Fur	11. Marital Status  1  Never Married 2  Married	If	Yes, specify Cuban,	panic Origin? (Specify , Mexican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whit	
21215-0036	ours afte tural", al Exor		3 Widowed 4 Divorced If Yes, Give Year or Dates.		☐ Yes 2 💆 No				ITE
215-	n 72 ho s. an "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give k	ent's Usual Occupat kind of work done du O NOT use retired)	ion ring most of working	16	6b. Kind of Business	Industry
	ed withi Hygiene other th	Be Co	17. Father's Name (First, Middle, Last)	CIV		ERING 18. Mother's Name (Fir	rot Middle Mai	ENGINEER	RING
/lan	should be filed n and Mental Hy 7 is marked oth raumatic event	To	EFRAIM	ROYTMAI		IDA	st, iviidale, iviai	· · · · · ·	NBERG
Maryland	1 and 2 should be f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) ZELDA ROYTMAN / WIFE	. 1		ROAD, #1D		-	
				0b. Place of Dispos		Date		C. Location - City o	
altimore,	Pag nen ant:		4 Donation 5 Other (Specify)  21, Signature of Funeral Service Licensee	BALTIMO	RE HEBREW	12/17/		REISTERST	
Ba	permit. Departr Imports any injt	1	May Ce	-	Name and Address	SOL I		N & BROS.	, INC.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					1/2017222	Approximate Interval Between Onset and Death
	h sician/ Medical		disease or condition a. Hupoten	nsequence of):					10 days
	Examiner	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con		fromyo,	ralby			13 years
1	ransit	Examiner	causé. Enter Underlying Cause (Disease or irinjury that initiated events	m arte	ny dis	ease	_		13 years
JVD	be executed sician and burial-transit	cal	resulting in death) Last Due to (or as a con	sequence of):	J				
8760	micate ng phys as the	Medi	IF FEMALE:					<u> </u>	
. Box 6876(	Ine law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🗍	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
s, P.O	requires that the de been signed by the should be detached	d by P	Part II. Other significant conditions contributing to death but no		nderlying cause give				o the cause of death?  Probably 4 Unknown
Vital Records,	aw requase been 2 shoul	Completed by	hupertensi on				24a. Was an autopsy		utopsy findings available completion of cause of
ğ H	n: Ine is ficate hi n', page		25. Was case referred to medical		00 Plan	as of Darth (Observation)	performe	d? death?	s 2 1 No
VIta	hysicial nis certi I directo	To Be	examiner?	2   ER/Outpatient	Toth-	ee of Death (Check only  4   Nursing Home		e 6 Other (Spec	cify)
n of	th. After the funeral	cate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28b. Time of injury	28c. Injury a work? M 1 🗌 Ye	at 28d. es 2 \( \sigma\) No	Describe how	injury occurred	
Division of	or Atter after dea Director in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - building, etc. (Sp.		et, factory, office		Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	io ne noopstal or Aeronong Prysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examiner	nation and/or investig	gation, in my opinion,	, death occurred at the	time, date and p	place, and due to the	cause(s) and manner stated.
1	no the within 2 To the comple	Ž	only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier	of my knowledge, de	eath occurred at the t 29c. License n	number	29d	I. Date signed (Mont	h, Day, Year)
			Jena Molys	MD	RES	-000		Ecembe	er 14, 2009
	3		30. Name and address of person who completed pause of death	SMa	HOSPI	tal of B	alth	Ecembe Nare	
Ī	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	barre				
_				0 00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #29a Per FH G898 12/18/09 Jh amend item 19a per fh g899 1-6-10 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2:5- PM SCOVENS JAMES December/177 EDWARD 2-9 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1+05 PITAL 7. Age (In yrs. last birthday) UNION MEMORIAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 2 /14/192 1 X M 2 □ F 217-16-1566 **Director** MARILAND Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director BALTIMORE 1 Syes 2 No MD 10e. Street and Number 10g. Citizen of What Country? ō 23a Funeral U.S.A. 2/2/5 AVENUE WOODMERE items ? 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 122444
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Black, White, etc. þ "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates. 6 30 46 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. U.S. Post OFFICE College (1-4 or 5+) Elementary/Şeconday (0-12) HANDLER 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ William EMMA HOLMES 19a. Informant's Name/Relationship (Type, Print)

Emma Scovens wife Ella Scovens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other tran 201 WOODMERE AVE. BALTIMORE MARVIAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pate Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MI'llS, MARYLAND 4 Donation 5 D Other (Specify) 2009 Signature of Funeral Service Linensee 22. Name and Address of Facility The DERRICK C. JOINES FIH, P.A. PARK HOLS, AVE. BALTIMORE ARVIANCE 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. proximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cogentive 6 Month Medical Due to (or as a consequence of) Examiner Pulmenary ue to lor as a consequence of Sequentially list conditions. Examine if any, leading to introdict cause. Enter Underlying attending physician and for use as the burlal-transit Cause (Disease or linjury vent as sociate that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant g Unknown Pregnant at time of death 1 Yes 2 No To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached if P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>မ</u> 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) At 2438946 b6 ponsa MD 12/17/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Leili parsa, Union memorial Hospital, Baltimere, mp 31. Date filed (Month, Day, Year)

DEC 18 2009 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 25,27,28a-Typer me,ggggg,12718705 and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Physician/ Month 2009 IL:10 AM ROSE SCHWARTZ ecem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospita Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Months Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 0471971909 MD **Director** 212-34-8841 100 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No BALTIMORE PIKESVILLE MD 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 7 SLADE AVENUE, #511 21208 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 🗆 Yes 2 🕅 No 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highe Elementary/Seconday (0-12) College (1-4 or 5+) CLERICAL WORKER VALLEY LIGHTING Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LAZINSKY SARAH MELTZER MORRIS Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE OSHRINE / DAUGHTER SLADE AVENUE, #511, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK! 12/10/2009 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) neumon Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events CERTIFICA Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death g 🗌 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by nomorrhage 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ction perform After this certificate I 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Denpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manne Death completed filled in by the funeral 28a. Date of injury
(Month, Day, Year)
November,
2009 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **Unknown**M atural 5 Pending work' Subject fell 1 ☐ Yes 2 X No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) / Slade Avenue, \$511, Pikesville, MD determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge of attended at the time date and blace, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number RES-000 December 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave, Baltimore, Maryland Pratt Hospital MD 31. Date filed (Month, Day, Year) DEC 18 2009 State Registrar

Schwar

Rose

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Kwown

Patient

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 Month Day 20[°]09 John Edward Scott 16 6:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Hours Min 1**X** M 2 □ F Director 89 1920 MD 8-01-2218 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U S 21205 2703 Beryl Avenue death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 within 72 hours after Specify: Black 1 ☐ Yes 2X No Specify. "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 16a, Decedent's Usual Occupation 15, Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 9th grade Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Annie Riley John Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S f Health tem 27 it 21231 Balto, 406 N. Washington Street Laverne Scott-daughter Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Garrison Forest 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-23-09 Owings Mills, 4 Donation 5 Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses Balto, MD 21202 ره (ر 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KNO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 441 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G898, 12/29/09, WS.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month 12 10 Day 2009 5:20 a M Idamae Stone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Sligo Creek Nursing Home If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Min. 06/15/1911 1 □ M 2 🖾 F Director 577**-**07-9507 98 Yrs DC Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tyryes 2 No DC NONE Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 332 Allison St. NW 20011 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Boston City Hospital Medical Secretary Be 18 Mother's Name (First Middle, Ida Ruth Dixon 17. Father's Name (First, Middle, Last) Charles W. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet Johnson/niece
20a. Method of Disposition Connecticut Ave. NW #620 Washington DC 20008 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2009 Cheltenham, MD Maryland Vet. Cem Marshall's Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 1400 Marshall 4217 9th St. NW Washington DC 20011 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiopulmonary Failure Medical resulting in death) Due to (or as a consequence of) Examiner Cerebral Vascular Acciden Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 2 **D**N completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XXNatural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical A certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/10/2009 MD D69800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tao Yu 7525 Carroll Ave. Takoma Park, MD 20912 31. Date filed (Month, Pay T'8 2009 Registrar's Signatur State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar			Cer	tificate of D	eath			09	40499	
	Physicia	ın/	1. Decedent's Name (First, Middle JULIA A						Date of Dea     Month	Day	Year	3. Time of Death	
	Medic		4a. Facility Name (if not institution				4b. City, Town, or L	anation of Doot	Decemb		2009	<u> </u>	
	- Examin	er							П		nty of Death ne Aru		
	Funeral		7726 Buckingha 5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Year	Jern If Under 24 Hrs		h	9. Birth	place (State or Foreign	
	Director		225-52-3201	1 □ M 2 <b>X</b> F	68	Yrs.	Months Days	Hours Min.	08-11-	1 9 4 1	Nort	h Carolina	
	d low	L	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loc	eation					10d. Inside City Limits	
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စ္တ	fter d , or i	ğ	1 Never Married 2 X Mar	ried Armed Forces?  1 Yes 2 X  If Yes, Give	No		Yes, specify Cuban,		o Rican, etc.)		lack, White,	etc.	
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פַ	illed v al Hyg l othe vent,	Be	17. Father's Name (First, Middle, I	ast)				18. Mother's Nai	me (First, Middle,	Maiden Surna	me)		
/lar	d be i Menta arked atic e	입	John Myers					Grace	E. Shee	ts			
lan	shoul and l is ma		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street an	d Number or Ru	ral Route Number	, City or Town	ity or Town, State, Zip Code)		
2	und 2 fealth im 27 her tr		Robert L. Smith	ı / Husband				m Nurse				yland 21144	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation			lace of Disposemetery, crem	sition (Name of natory or other place)		Date	20c. Locatio	n - City or To	own, State	
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Ba	permit Depar Impor any in		21. Signature Juneral Servi & L	Mug	do	]	Name and Address Donaldson 1411 Annar	Funeral	Home &	Cremat	ory, rvlan	P.A. d 21113	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused nly one cause on each line	the death	n. Do not ente	r the mode of dying,	such as cardiac	or respiratory arr	est,		Approximate Interval Between	
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Ë	nysici nis cel direc	10 E	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 I	ER/Outpatient	3 DOA Other:	4 D Nursing H	lome 5 Resid	ence 6 🗆 Ot	her (Specify	)	
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Division of Vital Records, P.O. Box 68	or Attendance after of Direct of in by	Se	4  Homicide determ	ned 28e. Place of Inju building, etc			et, factory, office		28f. Location (Si City or Town		ber or Rural	Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of xaminer: On the basis of ex	my knowle	edge, death o	ccured at the time, d	ate and place, a	I nd due to the cau at the time, date ar	se(s) and man	ner as state	d. use(s) and manner stated.	
	o the vithin 2 o the l	ž	only one) 3 Certifying  29b. Signature and title of certifier	Nurse Practioner: To the	best of my	knowledge, de	eath occurred at the ti	me, date and pla	ace, and due to the	cause(s) and r	nanner as st	ated.	
	F S F O		^ · · · · ·	MD, FA	cc			6010		12.15		**	
	51		30. Name and address of person v	ho completed cause of de	eath (Item	23a) (Type, Pr	int\		6 GL	EN BU		E	
			_ = ,	-1 10736					M	D 21	001		
	State	е	31. Date filed <i>(Month, Day, Year)</i> <b>RFC 1 8 2009</b>	32. Registra	r's Signatu	bark							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10b, per Fn g899 Ly 19/10 Th Certificate of Death Reg. No. 2 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Dec. Chivistine Siegmann 4a. Facility Name (If not institution, give street and Jumber) 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 14000c 7. Age (In yrs. last birthday) ber 6. Sex 7. A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min. Months Hours 1 □ M 2 F Yrs. 057-36-036 June 23, 1943 Director Usual Residence of Decedent 10b. Countyomerset Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Evarings must be notified at 1 Kes 2 No Funeral Director WD lacton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number AZU 21838 3752C bourne 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No altimore, Maryland 21215-0036 Specify. Specify: ģ 3 ☐ Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, I'm Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social DY Ker 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Siegmann မှ mond undin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) int of Health a t: If item 27 is 7 or other trai Hamilton, VA 20158 20a. Method of Disposition 17708 Madison Avenue daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Crematory 12-30-09
22. Name and Address of acility Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) tro 21. Signature of Funeral Service Licensee IIAM 1232 Mid Valley Dr. Jessup PA 18434 23a. Part Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concer, Left **Physician** letastatio Non Singl Cell 2 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 PYes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

committeely filled in by the fur 1 → Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia le 0-32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar